Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
DARREN GORE

Respondent Name
INSURANCE CO OF THE STATE OF P

MFDR Tracking Number
M4-14-0589-01

Carrier's Austin Representative Box
Box Number 19

MFDR Date Received
October 18, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We disagree with the amount paid as it appears that this claim was not paid using the 2013 TX Fee Schedule. We are not asking for review of a discounted amount. We are asking for reimbursement per the fee schedule."

Amount in Dispute: $17.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary:"Per CMS, physician assistants & nurse practitioners are allowed 85% of the fee schedule allowance for the physician. The 2013 TX fee schedule allowance for region 18 for CPT 99213 is $118.65X85%=$100.85."

Response Submitted by: Broadspire.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 12, 2013	99213	$17.80	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for E/M services.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 18- Exact duplicate claim/service (Use only with Group Code QA except where state workers' compensation regulations requires CO).
- 476- $119.00 of the charges are supplicates of bill #H-16020399-0.
- W1- Workers' compensation jurisdictional fee schedule adjustment. Note, if adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information).

Issues

1. Did the carrier correctly reimburse the requestor?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…"

   Regarding Physician Assistants, the CMS MLN Matters ICN 901623 dated September 2011 states in pertinent part "Services are paid at 85 percent of the amount that a physician is paid under the Medicare PFS…"

The division concludes that the carrier correctly calculated the reimbursement as follows:

$118.65 x 85%= $100.85.

2. For the reasons stated above, the service in dispute for June 12, 2013 is not eligible for payment pursuant to 28 Texas Administrative Code §134.203 (c).

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		April 22, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.