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
GREATER HOUSTON EMERGENCY PHYSICIANS

Respondent Name
CITY OF SAN ANTONIO

MFDR Tracking Number
M4-14-1221-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 31, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time, we would ask that you reconsider this claim for reimbursement or reprocess the denial to hold your member responsible."

Amount in Dispute: $358.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This bill was reconsidered on August 27, 2013 and an allowance of $94.71 was recommended. The enclosed explanation of benefits indicates check number 604XXXX was issued on August 29, 2013 in the amount of $97.71. Since the prior reimbursement was the maximum allowed amount under the DWC fee schedule, no additional amount is due."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 18, 2013	99283	$358.00	$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 fee guideline for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - W1A – Workers Compensation State Fee Schedule Adjustment. Reimbursement per Rule 134.203/134.204. Prior to March 1, 2008, Rule 134.202.
   - W3 – Additional payment made on appeal/reconsideration.
   - 29E – The time limit for filing has expired. Claim is to be submitted no later than the 95th day after the date on which the health care services are provided.

Issues

1. Did the insurance carrier issue payment for the disputed service rendered on March 18, 2013?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

   Per 28 Texas Administrative Code §134.203 "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

   The requestor seeks a total reimbursement in the amount of $358.00. Review of the submitted supplemental documentation in the form of EOBs submitted by the insurance carrier supports that payment in the amount of $94.71 was issued to the requestor for disputed date of service March 18, 2013, under check number 604XXXX. The MAR amount is $94.71, as a result, the requestor is not entitled to additional reimbursement for the disputed CPT code.
2. Review of the submitted documentation finds that the requestor is not entitled to additional reimbursement for the disputed CPT code 99283.

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

Signature	Medical Fee Dispute Resolution Officer	November 25, 2014 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 (20)** 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.