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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Elite Healthcare Fort Worth

Respondent Name
Hartford Underwriters Insurance

MFDR Tracking Number
M4-14-1852-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
February 24, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Office visits are recommended as determined to be medically necessary. Medical necessity for office visit in conjunction with work status form 73. All of this information was included in the reconsideration I set to the carrier before sending to MDR."

Amount in Dispute: $131.37

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "7/12/12-PLN 11 filed Carrier accepts bilateral sprain strain as the compensable injury. Carrier disputes diagnosis of CTS and the ganglion cysts or other conditions, body parts, diagnosis or symptoms."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 18, 2013	99213, 99080	$131.39	$131.39

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 professional medical services.
3. 28 Texas Administrative Code §129.5 sets outs out fee guidelines for work status reports.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 131 – Claim specific negotiated discount

- 217 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated arrangement
- 247 – A payment or denial has already been recommended for this service
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment

Issues

1. Did the requestor raise a new issue with their response?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. What is the rule applicable to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier states in their position statement, "Carrier disputes diagnosis of CTS and the ganglion cysts or other conditions, body parts, diagnoses or symptoms." Per 28 Texas Administrative Code §133.307 (d)(2)(F) states, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section." The respondent's position was not found on the explanation of benefits and therefore will not be considered in this review.

2. The insurance carrier denied disputed services with claim adjustment reason code 247 – "A payment or denial has already been recommended for this service." Review of the submitted documentation finds insufficient evidence to support the carrier's denial. Therefore, the services in dispute will be reviewed per applicable rules and fee guidelines.

3. 28 Texas Administrative Code 134.203 (c) states,

   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 (date of service yearly conversion factor).

   The services in dispute will be calculated as follows;

   - Per Medicare policy, procedure code 99213, service date October 18, 2013. The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.97. The practice expense (PE) RVU of 1.1 multiplied by the PE GPCI of 0.979 is 1.0769. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.826 is 0.05782. The sum of 2.10472 is multiplied by the Division conversion factor of $55.30 for a MAR of $116.39.

   - Procedure Code 99080, service date October 18, 2013. 28 Texas Administrative Code 129.5(i) states "Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15." This amount is recommended.

4. The total allowable reimbursement for the services in dispute is $131.39. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $131.39. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $131.39.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $131.39 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		October 15, 2015
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, 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 MFDR 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.