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
Del Mar Medical Center

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-14-2262-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 25, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Sedgwick paid only 17.00 for the office visit. Attached you will see the claim sent to Sedgwick in box 24F. The total amount is 170.00 not 17.00."

Amount in Dispute: $97.57

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written notification of medical fee dispute received however, no written report submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 7, 2013	99202	$97.57	$97.57

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 professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation state fee schedule adjustment
   - 309 – The charge for this procedure exceeds the fee schedule allowance
   - OA – The amount adjusted is due to bundling or unbundling of services

Issues

1. Did the requestor support the amount billed?
2. What is the applicable rule pertaining to allowed amount?

3. Is the requestor entitled to reimbursement?

Findings

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on April 2, 2014. The insurance carrier did not submit a response for consideration in this review. Per the Division's former rule at 28 Texas Administrative Code §133.307(d)(1), effective May 25, 2008, 33 *Texas Register* 3954, "If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information." Accordingly, this decision is based on the available information.
2. Review of the submitted documentation finds the copy of the CMS 1500 shows $170.00 to be the amount billed. The requestors' statement is supported. The disputed service will be reviewed per applicable rules and fee guidelines.
3. 28 Texas Administrative Code §134.203 (c) states in pertinent part, "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).
    - Procedure code 99202, service date May 7, 2013, represents a professional service with reimbursement determined per §134.203(c). 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 0.93 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.93. The practice expense (PE) RVU of 1.19 multiplied by the PE GPCI of 0.912 is 1.08528. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.809 is 0.05663. The sum of 2.07191 is multiplied by the Division conversion factor of $55.30 for a MAR of $114.58.
4. The total allowable reimbursement for the services in dispute is $114.58. The amount previously paid by the insurance carrier is $17.00. The requestor is seeking additional reimbursement in the amount of $97.57. 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 $97.57.

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 $97.57 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 22, 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** 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.