



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

Thomas A Kingman MD

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-14-2284-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

March 26, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient presented to the emergency room with a history of difficulty walking and difficulty voiding... Dr. Kingman admitted him to the hospital for further testing to make sure they were not missing anything."

Amount in Dispute: \$300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The documentation from THOMAS A KINGMAN MD does not show a medical emergency with respect to the definition of such at Rule 133.2(a)(4)(A)."

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
December 28, 2013	99223	\$300.00	\$300.00

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 197 – Precertification/authorization/notification absent.
 - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

- Does the billed service require prior authorization?

2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services with reason code, 197 – “Precertification - authorization - notification absent. “ Review of the submitted medical claim finds the submitted code is CPT code 99223. This code is defined as, “Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.” 28 Texas Administrative Code §134.600 (p) states in pertinent part, “(p) Non-emergency health care requiring preauthorization includes:(1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay; (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section; (3) spinal surgery; (4) all work hardening or work conditioning services requested by: (A) non-exempted work hardening or work conditioning programs; or (B) division exempted programs if the proposed services exceed or are not addressed by the division's treatment guidelines as described in paragraph (12) of this subsection; (5) physical and occupational therapy services..” The disputed service is an evaluation and management code not emergency services and per the above stated rule does not require prior authorization. The carriers’ denial is not supported. The disputed service will be reviewed per applicable rules and fee guidelines.
2. 28 Texas Administrative Code §134.203 (h) states in pertinent part, “(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.”
 - Procedure code 99223, service date December 28, 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 3.86 multiplied by the geographic practice cost index (GPCI) for work of 1 is 3.86. The practice expense (PE) RVU of 1.67 multiplied by the PE GPCI of 0.912 is 1.52304. The malpractice RVU of 0.29 multiplied by the malpractice GPCI of 0.809 is 0.23461. The sum of 5.61765 is multiplied by the Division conversion factor of \$55.30 for a MAR of \$310.66. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is \$300.00.
3. The total allowable reimbursement for the services in dispute is \$300.00. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$300.00. 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 \$300.00.

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 \$300.00 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

January , 2015
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.