



**TEXAS DEPARTMENT OF INSURANCE**

**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**  
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**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**GENERAL INFORMATION**

**Requestor Name**

Elite Healthcare Fort Worth

**Respondent Name**

Indemnity Insurance Co of North

**MFDR Tracking Number**

M4-15-1334-02

**Carrier's Austin Representative**

Box Number 15

**MFDR Date Received**

January 5, 2015

**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."

**Amount in Dispute:** \$239.66

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** Written acknowledgement of medical fee dispute received however no position statement submitted.

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 16 – 21, 2014	99213, 99080	\$239.66	\$239.66

**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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §126.14 sets out procedures for treating doctor examinations.
- 28 Texas Administrative Code §129.5 sets out reimbursement guidelines for work status reports.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 165 – Payment denied / reduced for absence of, or exceeded referral

## Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the rule regarding applicable fee schedule?
3. Is the requestor entitled to additional reimbursement?

## Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 165 – "Payment denied / reduced for absence of, or exceeded referral". 28 Texas Administrative Code §124.14 (l) states, "If the insurance carrier denies an injury or diagnosis identified in this examination, all treatment for that injury or diagnosis must be preauthorized prior to treatment occurring. For the treating doctor, the insurance carrier's denial is effective on the date the written notice of denial is received by the doctor. The preauthorization requirement continues until the injury or diagnosis is determined to be part of the compensable injury through dispute resolution or agreement of the parties." Review of the submitted documentation finds;

- a. Nothing to support denial of injury or diagnosis associated with the treating physician's examination.

Carrier's denial is not supported. Therefore, the services in dispute will be reviewed per applicable rules and fee guidelines.

2. 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). The maximum allowable reimbursement will be calculated as follows;
- Procedure code 99213, service date April 16, 2014, 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 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.002 is 0.97194. The practice expense (PE) RVU of 1 multiplied by the PE GPCI of 0.987 is 0.987. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.799 is 0.05593. The sum of 2.01487 is multiplied by the Division conversion factor of \$55.75 for a MAR of \$112.33.
  - Procedure code 99213, service date April 21, 2014, 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 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.002 is 0.97194. The practice expense (PE) RVU of 1 multiplied by the PE GPCI of 0.987 is 0.987. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.799 is 0.05593. The sum of 2.01487 is multiplied by the Division conversion factor of \$55.75 for a MAR of \$112.33.
  - Procedure code 99080, service date April 21, 2014, is specific to Worker's Compensation Services. 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. A doctor shall not bill in excess of \$15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under

subsections (d)(1), (d)(2), and (f) of this section; The allowed amount is \$15.00.” This amount is recommended.

3. The total allowable reimbursement for the services in dispute is \$239.66. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$239.66. 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 \$239.66.

### ***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 \$239.66 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	Date
		May , 2015

### ***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.**