



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

New Hampshire Insurance Company

MFDR Tracking Number

M4-15-1707-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

February 9, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Treating provider is a chiropractor and the procedure code that is being billed out is correct for his practice."

Amount in Dispute: \$165.84

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Division Note: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged as received on February 18, 2015. 28 Texas Administrative Code §133.307(d)(1) requires that:

The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. 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.

The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 25, 2014	Evaluation & Management, established patient (99214)	\$165.84	\$165.83

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 fee guidelines for billing and reimbursing professional

medical services.

3. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of medical bills.
4. 22 Texas Administrative Code §78.13 defines the scope of practice for chiropractors.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 8 – The procedure code is inconsistent with the provider type/specialty (taxonomy).
 - P12
 - P300

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied the disputed services with claim adjustment reason code 8 – "The procedure code is inconsistent with the provider type/specialty (taxonomy)." 28 Texas Administrative Code §134.203(a)(6) states, "Notwithstanding Medicare payment policies, chiropractors may be reimbursed for services provided within the scope of their practice act."

22 Texas Administrative Code §78.13(c)(2) states, "To evaluate and examine individual patients or patient populations, licensees of this board are authorized to use: (A) physical examinations." Therefore, the disputed service is within the scope and practice of the requestor's license. The insurance carrier's denial reason is not supported.

2. 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 \$52.83...

(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...

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. The Division conversion factor for 2014 is \$55.75.

For procedure code 99214 on September 25, 2014, the relative value (RVU) for work of 1.5 multiplied by the geographic practice cost index (GPCI) for work of 1.002 is 1.503. The practice expense (PE) RVU of 1.41 multiplied by the PE GPCI of 0.987 is 1.39167. The malpractice (MP) RVU of 0.1 multiplied by the MP GPCI of 0.799 is 0.0799. The sum of 2.97457 is multiplied by the Division conversion factor of \$55.75 for a MAR of \$165.83.

3. The total allowable for the disputed service is \$165.83. The insurance carrier paid \$0.00. Therefore, a reimbursement of \$165.83 is recommended.

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 \$165.83.

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 \$165.83 reimbursement for the disputed services.

Authorized Signature

Signature

Laurie Garnes
Medical Fee Dispute Resolution Officer

January 15, 2016
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.