



**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**

Nix Medical Center

**Respondent Name**

New Hampshire Insurance Co

**MFDR Tracking Number**

M4-15-1880-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

February 20, 2015

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "These chest x-rays were performed by different providers. Our request for reconsideration was denied. We would like to receive final adjudication on this claim."

**Amount in Dispute:** \$14.06

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

**Response Submitted by:** Flahive, Ogden & Latson

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 5, 2014	71010	\$14.06	\$14.06

**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 §134.203 sets out the reimbursement guidelines for professional services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 247 – A payment or denial has already been recommended for this service

## **Issues**

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

## **Findings**

1. The insurance carrier denied disputed services with claim adjustment reason code 247 – "A payment or denial has already been recommended for this service." 28 Texas Administrative Code §134.203 (b) requires that "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits;" Review of the submitted information finds that
  - a. Documents from Department of Radiology shows; Admission date – September 5, 2014 9:47 am, September 5, 2014 2:11 pm.
  - b. Impression from earlier note: "PICC line appears to terminate under the clavicular region. Consider repositioning and repeat PA and lateral chest x-ray as felt clinically appropriate.
  - c. Impression from later note: "Appropriate positioning of the left sided PICC line."

The Division finds the requestor supported there were two distinct procedures performed. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division 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;
  - a. Procedure code 71010, service date September 5, 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 0.18 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.18. The practice expense (PE) RVU of 0.47 multiplied by the PE GPCI of 0.916 is 0.43052. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.816 is 0.01632. The sum of 0.62684 is multiplied by the Division conversion factor of \$55.75 for a MAR of \$34.95. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is \$31.00.
3. The total allowable reimbursement for the services in dispute is \$31.00. The amount previously paid by the insurance carrier is \$0.00. The requestor is seeking additional reimbursement in the amount of \$14.06. 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 \$14.06.

**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 \$14.06 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

July , 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, 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.**