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
Shannon Clinic

Respondent Name
Nationwide Agribusiness Insurance

MFDR Tracking Number
M4-15-2193-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
March 18, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our office visit services for Dr. Jackie Preston denied as duplicate of Dr. Andrew Kingman charges incorrectly. As noted in our appeal dated 01/15/15, patient was seen by multiple providers of Shannon Clinic and they all bill under Shannon Clinic TIN 75-2600873."

Amount in Dispute: $159.00

RESPONDENT'S POSITION SUMMARY

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

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 5, 2014	99221	$159.00	$153.58

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 reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 18 – Exact duplicate claim/service
   - 224 Duplicate charge

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the rule applicable to fee guidelines?
3. Is the requestor entitled to additional 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 March 26, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "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.
2. The insurance carrier denied disputed services with claim adjustment reason code 18 – "Exact duplicate claim/service." Review of the submitted information finds that no documentation was found to support that this date of service had been paid to this provider previously. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
3. 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 (date of service yearly conversion factor)." The maximum allowable reimbursement will be calculated as follows;

    - Procedure code 99221, 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 1.92 multiplied by the geographic practice cost index (GPCI) for work of 1 is 1.92. The practice expense (PE) RVU of 0.76 multiplied by the PE GPCI of 0.916 is 0.69616. The malpractice RVU of 0.17 multiplied by the malpractice GPCI of 0.816 is 0.13872. The sum of 2.75488 is multiplied by the Division conversion factor of $55.75 for a MAR of $153.58.

4. The total allowable reimbursement for the services in dispute is $153.58. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $153.58. 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 $153.58.

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 $153.58 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		May , 2015
Signature	Medical Fee Dispute Resolution Officer	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.