



**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**

Texas Health dba Injury 1

**Respondent Name**

New Hampshire Insurance Co

**MFDR Tracking Number**

M4-16-1018-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

December 17, 2015

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "CPT code 90837 was preauthorized. #1636869 therefore it is deemed medically necessary."

**Amount in Dispute:** \$598.50

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Please see the EOBs. The carrier is in the process of sending additional payment to the provider. If the provider should receive the full amount it is requesting through medical dispute resolution, then the carrier requests that the provider withdraw its request for medical dispute resolution."

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

**SUMMARY OF FINDINGS**

| Dates of Service       | Disputed Services | Amount In Dispute | Amount Due |
|------------------------|-------------------|-------------------|------------|
| April 15, 22, 29, 2015 | 90837             | \$598.50          | \$598.50   |

**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 Part 1, Chapter 19, Subchapter U sets out the requirements for utilization review of health care provided under Texas workers' compensation insurance coverage.
- 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:
  - 219 – Based on extent of injury

- 216 – Based on the findings of a review organization

### 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 219 – “Based on extent of injury” and denial code 216 – “Based on the findings of a review organization.” 28 Texas Administrative Code §133.307 (d)(2) states that the respondent **shall** [emphasis added] provide the following information and records as part of its response to medical fee dispute:

(H) If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements)

(I) If the medical fee dispute involves medical necessity issues, the insurance carrier shall attach a copy of documentation that supports an adverse determination in accordance with §19.2005 of this title (relating to General Standards of Utilization Review).

Review of the submitted information finds that a copy of the Plan Language Notice in accordance with §124.2(d)(f) was not provided by the carrier as required. Similarly, no documentation that supports an adverse determination in accordance with §19.2005 was provided by the carrier as part of its response to medical fee dispute.

Additionally, the carrier states in its response that “The carrier is in the process of sending additional payment to the provider.” As the documentation required by above referenced rules was not found and the carrier was to pay rather than maintain their denial, the Division will review the services in dispute based on applicable rules and fee guidelines.

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 (date of service yearly conversion factor).

The maximum allowable reimbursement is calculated as follows;

$$\text{(DWC Conversion Factor / Medicare Conversion Factor)} \times \text{Allowable} = \text{TX Fee MAR or}$$
$$(56.2/35.7547) \times \$126.93 = \$199.51$$

The MAR for dates of service April 15, 22, and 29, 2015 is \$199.51 each for a total of \$598.53.

3. The maximum allowable reimbursement for the services in dispute is \$598.53. The requestor is seeking \$598.50. 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 \$598.50.

**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 \$598.50 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

February 29, 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.**