



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

HCAA Medical Group PA

Respondent Name

Old Republic Insurance Co

MFDR Tracking Number

M4-16-1035-01

Carrier's Austin Representative

Box Number 44

MFDR Date Received

December 16, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These charges were accrued when he saw the therapist. I have sent the bill in over 5x times and every time I get denied."

Amount in Dispute: \$99.79

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent was previously remitted \$89.81 on July 8, 2015 to satisfy this matter."

Response Submitted by: White Espey, P.O. Box 152949, Austin, TX 78715

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 11, 2015	97001	\$99.79	\$10.78

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 medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - W3 – Additional payment made on appeal/reconsideration
 - 304 – This service is included in the value of the office visit or other procedure
 - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment
- 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 that pertains to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code B13 – “Previously paid. Payment for this claim/service may have been provided in a previous payment.” Review of the submitted documentation finds;
 - Explanation of Bill Review for 97001 on Date of Service May 11, 2015. Total recommended allowance of \$89.01. Payment Date: July 8, 2015, Payment Method: Electronic Funds Transfer

The respondent provided evidence of above mentioned payment. The Maximum Allowable Reimbursement will be calculated below.

2. 28 Texas Administrative Code §134.403 (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 MAR is calculated as (DWC Conversion Factor / Medicare Conversion Factor) x Participating Amount or
 $(56.2 / 35.7547) \times \$72.70 = \$114.27$

3. The maximum allowable reimbursement for the service in dispute is \$114.27. The requestor is seeking \$99.79. The carrier previously paid \$89.01. The remaining balance is \$10.78. 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 \$10.78.

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 \$10.78 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	January 20, 2016 Date
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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.