TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Orthotexas Physician

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-17-3630-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 11, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On this date of service, this claim was denied stating "new patient qualifications were not met". Dr. Knoll & Dr. Glogau are different specialties with different taxonomy codes. Dr. Knoll is a hand specialist and should be reimbursed for the initial evaluation visit she charged for on this date of service. See the attached documentation that supports the services provided."

Amount in Dispute: $250.00

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
January 30, 2017	99203	$250.00	$167.68

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 claims.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - B16 – "New patient qualifications were not met"

- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issues

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

Findings

1. The requestor is seeking $250.00 for code 99203 – "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family" rendered on January 30, 2017.

   The insurance carrier denied disputed services with claim adjustment reason code B16 – "New patient" qualifications were not met. 28 Texas Administrative Code §134.203 (a) (5) and (b) state in pertinent parts,

   > (a) (5) "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare
   >
   > (b) 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; modifiers;

   The requestor states in their position statement, "Dr. Knoll & Dr. Glogau are different specialties…" Review of the applicable Medicare payment policy found at www.cms.gov, Medicare Claims Processing Manual, Chapter 12, Section 30.6.7, A. The definition of new patient for selection of E/M visit code;

   > *Interpret the phrase "new patient" to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous 3 years.*

   The respondent did not submit any documentation to support that a "new patient" payment was made to Dr. Knoll or another group practice physician with the same specialty. Therefore, the carrier's denial is not supported. The date of service in dispute will be reviewed per the applicable fee guideline below.

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).

   Review of the 2017 Physician Fee Schedule for code 99203, "Rest of Texas" finds an allowable of $104.66.

   The calculation of the maximum allowable reimbursement is (DWC Conversion Factor/Medicare Conversion Factor) x allowable = MAR or (57.5/35.8887) x $104.66 = $167.68.

3. The maximum allowable reimbursement for the service in dispute is $167.68. The carrier previously paid $0.00. The remaining balance of $167.68 is due to the requestor.

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 $167.68.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $167.68, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		September 1, 2017
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 Rule §133.307, effective May 31, 2012, *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. **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.