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
Dallas Testing Inc

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-18-3190-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
May 1, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The charge does not exceed the fee scheduled value."

Amount in Dispute: $16.95

RESPONDENT'S POSITION SUMMARY

The Austin carrier representative for Indemnity Insurance Co of North America is Downs Stanford. Downs Stanford acknowledged receipt of the copy of this medical fee dispute on May 8, 2018.

28 Texas Administrative Code §133.307 states, in relevant part:

> (d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
> (1) Timeliness. 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** [emphasis added]. 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.

Review of the documentation finds that no response has been received on behalf of Indemnity Insurance Co of North America from Downs Stanford to date. The division concludes that Indemnity Insurance Co of North America failed to respond within the timeframe required by §133.307(d)(1). For that reason the division will base its decision on the information available.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 2, 2018	95912, 95886	$16.95	$0.00

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:
   - P12 - Workers compensation jurisdictional fee schedule adjustment

Issues

1. Are the insurance carrier's reasons for reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced the disputed services with claim adjustment reason code P12 – "Workers' compensation jurisdiction fee schedule adjustment." 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 MAR is calculated as follows: Workers Compensation Factor/Medicare Conversion Factor x Medicare allowable.

- Procedure code 95912 has an allowable of $258.46. 58.31/35.9996 x $258.46 = $418.64
- Procedure code 95886 has an allowable of $89.51. 58.31/35.9996 x $89.51 = $144.98

The total allowable is $563.62. The carrier paid $575.71. No additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		August 9, 2018
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.