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
NATIONAL INTERSTATE INSURANCE

MFDR Tracking Number
M4-19-0378-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
September 24, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Patient had a hearing and the carrier was ordered to pay all unpaid services with interest. I have included a copy of the decision and order."

Amount in Dispute: $132.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "National has re-processed the bill under the correct date of injury and the correct claim number. See the Explanation of Benefits dated 10/09/18 at Exhibit A. National also has issued payment for the disputed amount of $132.66. See the payment screen at Exhibit B. National requests that Requestor withdraw its request for fee dispute resolution upon verifying that it was received the payment."

Response Submitted by: Stone Loughlin Swanson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 10, 2017	97163-GP	$132.66	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 fee guideline for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits
   - 190 – Extent not finally adjudicated
   - 219 – Based on extent of injury

Issues

1. Did the insurance carrier issue payment for the disputed services rendered on May 10, 2017?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.203 "(c) 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 $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

   Per 28 Texas Administrative Code §134.203 "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

   The requestor seeks a total reimbursement in the amount of $132.66. Review of the documentation in the form of EOBs submitted by the insurance carrier supports that payment in the amount of $132.66 was issued to the requestor for disputed date of service May 10, 2017, under check #00110052703, cleared by the bank on October 9, 2018. As a result, the requestor is not entitled to additional reimbursement for the disputed service.
2. Review of the submitted documentation finds that the requestor is not entitled to additional reimbursement for the disputed CPT codes 97163-GP rendered on May 10, 2017.

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 upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 11, 2019 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, 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 MDR 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.