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
PATIENTS CHOICE FAMILY MEDICINE

Respondent Name
ACCIDENT FUND GENERAL INSURANCE CO.

MFDR Tracking Number
M4-19-3103-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
February 12, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I have received an EOB denial … stating 'PEER REVIEW… Our office feels this is an invalid denial due … this is an office visit with a work status report … Dr. Dayian is the treating doctor on file it is his responsibility to monitor the patient's treatment. Furthermore this patient … has not reached MMI."

Amount in Dispute: $178.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
October 18, 2018	Professional Medical Services	$178.88	$133.65

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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. 28 Texas Administrative Code §129.5 sets out guidelines regarding work status reports.
4. 28 Texas Administrative Code §19.2005 sets out general standards of utilization review.
5. Texas Labor Code §413.031entitles health care providers to a review of services if payment is denied.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 203 – PEER REVIEW HAS DETERMINED - PAYMENT FOR TREATMENT HAS NOT BEEN RECOMMENDED DUE TO THE LACK OF MEDICAL NECESSITY. PEER REVIEW HAS PROVIDED ITS FINDINGS TO THE PROVIDER IN PRIOR DOCUMENTATION.
   - 216 – BASED ON THE FINDINGS OF A REVIEW ORGANIZATION.
   - 309 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

Issues

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

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes:
   - 203 – PEER REVIEW HAS DETERMINED - PAYMENT FOR TREATMENT HAS NOT BEEN RECOMMENDED DUE TO THE LACK OF MEDICAL NECESSITY. PEER REVIEW HAS PROVIDED ITS FINDINGS TO THE PROVIDER IN PRIOR DOCUMENTATION.
   - 216 – BASED ON THE FINDINGS OF A REVIEW ORGANIZATION.

   28 Texas Administrative Code §133.307(d)(2)(I) requires that if the 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)."

   The insurance carrier's representative acknowledged receipt of the request for medical fee dispute resolution on February 20, 2019. The division contacted the carrier's representative on March 20, 2019 to inquire whether they intended to respond. As of the date of this review, the carrier has not responded.

   Rule §133.307(d)(1) provides that "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."

   Consequently, the findings in this decision are based on the information available at the time of review.

   The insurance carrier did not respond or provide a copy of the alleged peer review nor attach any documentation to support an adverse determination, as required by Rule §133.307(d)(2)(I). The division thus concludes the carrier failed to support its payment denials based on peer review or the findings of a review organization.

   The insurance carrier's denial reasons are not supported. The disputed services will therefore be reviewed for payment in accordance with division rules and fee guidelines.

2. This dispute regards evaluation services with reimbursement subject to the *Medical Fee Guideline for Professional Services*, 28 Texas Administrative Code §134.203, requiring the maximum allowable reimbursement (MAR) be determined by Medicare payment policies modified by DWC rules. The MAR is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the DWC annual conversion factor.

   Reimbursement is calculated as follows:

   - Procedure code 99213 has a Work RVU of 0.97 multiplied by the Work GPCI of 1.007 is 0.97679. The practice expense RVU of 1.02 multiplied by the PE GPCI of 0.986 is 1.00572. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.747 is 0.05229. The sum is 2.0348 multiplied by the DWC conversion factor of $58.31 for a MAR of $118.65.
   - Procedure code 99080-73 is a division specific code for a work status report with payment subject to 28 Texas Administrative Code §129.5(i), which requires that "reimbursement shall be $15."

   The total allowable reimbursement for the disputed services is $133.65. The insurance carrier paid $0.00. The amount due is $133.65. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division emphasizes the findings in this decision are based on the available evidence presented by the requestor and respondent up to the time of review. Even though not all the evidence was discussed, it was considered.

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 $133.65.

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 $133.65, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	April 18, 2019
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.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.