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
IKECHUKWU OBIH, MD

Respondent Name
TORUS NATIONAL INSURANCE CO

MFDR Tracking Number
M4-20-0521-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
OCTOBER 23, 2019

REQUESTOR'S POSITION SUMMARY

"The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134."

Supplemental Position dated November 14, 2019: "The provider received the attached response from the carrier stating that they never received an initial submission prior to the submission of the MDR request. Attached are 4 separate submission to the carrier, all within the 95 day submission."

Amount in Dispute: $242.38

RESPONDENT'S POSITION SUMMARY

"Although the carrier has received other bills from the provider, the carrier did not receive a bill for the April 16, 2019 date of service. The carrier's receipt of the DWC-60 on October 30, 2019 represents the carrier's first receipt of the provider's medical bill. The carrier is processing the bill and is not going to dispute it except any reimbursement will be pursuant to the Medical Fee Guideline."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 16, 2019	CPT Code 99215 Office Visit	$242.38	$242.38

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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
3. Neither party to the dispute submitted any explanation of benefits.

Issues

Does the documentation support billing CPT code 99214? Is the requestor due reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $242.38 for CPT code 99215, rendered on April 16, 2019.
2. The respondent wrote, "The carrier is processing the bill and is not going to dispute it except any reimbursement will be pursuant to the Medical Fee Guideline."
3. The fee guidelines for disputed services is found in 28 TAC §134.203.
4. 28 TAC §134.203(a)(5) states "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."

   CPT code 99215 is described as, "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high 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 to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family."

   The DWC finds the documentation supports 2 of the 3 key components; therefore, reimbursement is recommended.

5. Per 28 TAC §134.203(c)(1)(2), "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. The following hypothetical example illustrates this annual adjustment activity if the DWC had been using this MEI annual percentage adjustment: The 2006 DWC conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007

   MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) DWC conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2019 DWC conversion factor for this service is 59.19.

   The Medicare Conversion Factor is 36.0391

Review of Box 32 on the CMS-1500 the services were rendered in Austin, Texas.

The Medicare participating amount for code 99215 is $147.79.

Using the above formula, the MAR is $242.73 or less. The requestor is seeking reimbursement of $242.38. The respondent paid $0.00. The DWC finds, the requestor is due reimbursement of $242.38.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $242.38.

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 $242.38, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

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Authorized Signature

		11/15/2019
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 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **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.