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

Requester Name
ORTHOTEXAS PHYSICIANS & SURGEONS

Respondent Name
HARTFORD UNDERWRITERS INSURANCE

MFDR Tracking Number
M4-20-3022-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
August 31, 2020

REQUESTER'S POSITION SUMMARY

"Per Rule 134.600 & Labor Code Sec. 408.021 states no authorization is required for an office visit for a compensable injury."

Amount in Dispute: $215.00

RESPONDENT'S POSITION SUMMARY

"The disputed service is not related to the compensable injury."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 22, 2020	Evaluation and Management (99213)	$200.00	$122.40
May 22, 2020	Work Status Report (99080-73)	$15.00	$15.00
	Total	$215.00	$137.40

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 (DWC).

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 guidelines for professional services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment denied/reduced for absence of precertification/authorization.
   - APPR – Reimbursement is being withheld as the treating doctor and/or services rendered were not approved based upon handler review. If you require additional information regarding this bill decision, contact the claim handler.

- W3 – Additional payment made on appeal/reconsideration.

Issues

1. Did Hartford Underwriters Insurance raise a new defense in its response?
2. Is the insurance carrier's reason for denial of payment supported?
3. Is OrthoTexas Physicians and Surgeons entitled to reimbursement for the services in question?

Findings

1. OrthoTexas Physicians and Surgeons is seeking reimbursement for an evaluation and management examination and a Work Status Report. In its position statement, The Hartford, on behalf of the insurance carrier, argued that "The disputed service is not related to the compensable injury."

   The response from the insurance carrier is required to address only the denial reasons presented to the health care provider before to the request for medical fee dispute resolution (MFDR) was filed with the DWC. Any new denial reasons or defenses raised shall not be considered in this review.[1]

   The submitted documentation does not support that a denial based on extent of the compensable injury was provided to the requester before this request for MFDR was filed. Therefore, the DWC will not consider this argument in the current dispute review.

2. Per explanations of benefits dated July 15, 2020, and August 14, 2020, the insurance carrier denied payment of the services in question based on preauthorization. Evaluation and management services and work status reports do not require preauthorization.[2] The DWC concludes that the insurance carrier's denial of payment is not supported.

3. Because the insurance carrier's denial of payment was not supported, the requester is entitled to reimbursement for the services in question.

   Reimbursement for the testing in question is based on Medicare policies using the conversion factor determined by the division for the appropriate year.[3] The conversion factor for 2020 is $60.32.[4] Therefore reimbursement for the evaluation and management examination in question is $122.40. Reimbursement for completing a Work Status Report is $15.00.[5]

   The total reimbursement for the services in dispute is $137.40. This amount is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requester has established that additional reimbursement is due. As a result, the amount ordered is $137.40.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requester is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requester $137.40, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

[1] 28 TAC §133.307 (d)(2)(F)
[2] 28 TAC §134.600 (p)
[3] 28 TAC §134.203(b) and (c)
[4] https://www.tdi.texas.gov/wc/fee/conversionfactors.html#conv
[5] 28 TAC §129.5 (j)

Authorized Signature

		October 8, 2020
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 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 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.