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
MANUEL SANCHEZ MD

Respondent Name
DONNA ISD

MFDR Tracking Number
M4-21-0390-01

Carrier's Austin Representative
Box Number 29

MFDR Date Received
November 6, 2020

Response Submitted By:
Claims Administrator Services, Inc.

REQUESTOR'S POSITION SUMMARY

"It is our position that the carrier has denied payments of the services provided inappropriately and is responsible for several bills still owed. We are confident that the enclosed information clearly substantiates the Doctors' position under the DWC Medical Fee payment policies and rules."

RESPONDENT'S POSITION SUMMARY

"All but one of the charges in question have been reprocessed and reimbursed. Copies of EOBs/Checks are attached. The only bill not reprocessed was the Impairment Rating fee for $50.00 incurred on 1/14/2020. Based on the BRC agreement, the claimant was certified with a 4% Impairment on 2/7/2019. This $50.00 fee from Dr. Sanchez was unwarranted and invalid."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 25, 2018 through February 4, 2020	99213, 99080-15, 97163, 97110 and 99455	$2,100.00	$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 (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §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:
   - 742 & P4 – Workers compensation claim adjudicated as non-compensable. This payer is not liable for claim or service/treatment.
   - 304 – MMI or IR certification is not valid for this date of service.
   - B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.

Issues

1. Did the insurance carrier issue payment for dates of services October 25, 2018 through December 14, 2019 and February 4, 2020?
2. Did the insurance carrier issue payment for CPT Code 99455-V5 rendered on January 14, 2020?
3. Is the requestor entitled to reimbursement for CPT Code 99455-V5?

Findings

1. The requestor seeks reimbursement for dates of service October 25, 2018 through December 14, 2019 and February 4, 2020. Per 28 TAC §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 TAC §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 MAR amount for the disputed services is $1,669.62. Review of the submitted documentation in the form of EOBs submitted by the insurance carrier supports that payments totaling $1,669.62 were issued to the requestor for disputed dates of service October 25, 2018 through December 14, 2019 and February 4, 2020. As a result, the requestor is not entitled to additional reimbursement for the disputed CPT codes.

DOS	CPT CODE	AMT DISPUTE	AMT PAID	MAR	AMT DUE
10/25/2018	99213	$150.00	$115.60	$115.60	$0.00
10/25/2018	99080	$15.00	$15.00	$15.00	$0.00
11/8/2018	99213	$150.00	$115.60	$115.60	$0.00
11/8/2018	99080	$15.00	$15.00	$15.00	$0.00
12/12/2018	99213	$150.00	$115.60	$115.60	$0.00
12/12/2018	99080	$15.00	$15.00	$15.00	$0.00
1/3/2019	99213	$150.00	$119.01	$119.01	$0.00
1/3/2019	99080	$15.00	$15.00	$15.00	$0.00
1/22/2019	99213	$150.00	$119.01	$119.01	$0.00
1/22/2019	99080	$15.00	$15.00	$15.00	$0.00
7/12/2019	99213	$150.00	$119.01	$119.01	$0.00
7/12/2019	99080	$15.00	$15.00	$15.00	$0.00
8/14/2019	99213	$150.00	$119.01	$119.01	$0.00
8/14/2019	99080	$15.00	$15.00	$15.00	$0.00
9/30/2019	99213	$150.00	$119.01	$119.01	$0.00
9/30/2019	99080	$15.00	$15.00	$15.00	$0.00
10/21/2019	99213	$150.00	$119.01	$119.01	$0.00
10/21/2019	99080	$15.00	$15.00	$15.00	$0.00
12/4/2019	97163	$175.00	$137.24	$137.24	$0.00
12/4/2019	97110 x 4	$225.00	$199.12	$199.12	$0.00
1/14/2020	99455-VR	$50.00	$0.00	$0.00	$0.00
2/4/2020	99213	$150.00	$122.40	$122.40	$0.00
2/4/2020	99080	$15.00	$15.00	$15.00	$0.00
	TOTAL	$2,100.00	$1,669.62	$1,669.62	$0.00

2. The requestor seeks $50.00 for CPT Code 99455-V5 rendered on January 14, 2020. The insurance carrier denied the disputed CPT Code with denial reduction codes 304 and B7 (description provided above.) Review of the submitted documentation finds that the insurance carrier's denial reason is supported. As a result, the requestor is not entitled to reimbursement for the disputed CPT codes 99455-VR rendered on January 14, 2020.

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 29, 2021 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.