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
DONALD MCPHAUL, MD

Respondent Name
OLD REPUBLIC GENERAL INSURANCE CORP

MFDR Tracking Number
M4-21-2145-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
JULY 22, 2021

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: $221.38

RESPONDENT'S POSITION SUMMARY

"Supplemental response will be provided once the bill auditing company has finalized their review."

Supplemental Response: "Additional Allowed amount - $221.76. Payment date – 7/2/21. Payment Status - CLEARED."

Responses Submitted By: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 10, 2021	CPT Code 99214-25 New Patient Office Visit	$221.38	$0.00
	CPT Code 95886 (X2) Needle EMG	$0.00	$0.00
	CPT Code 95912 Nerve Conduction Studies	$0.00	$0.00
TOTAL		$221.38	$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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective February 22, 2021, sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced / denied by the respondent with the following reason code:

   - 00168-Payment adjusted because the payer deems the information submitted does not support his level of service.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 150-Payment adjusted because the payer deems the information submitted does not support the level of service.
   - B13- Previously paid. Payment for this claim/service may have been provided in a previous payment
   - 247-A payment or denial has already been recommended for this service.
   - 90202-Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to reimbursement for CPT code 99214-25 rendered on March 10, 2021?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $221.38 for CPT code 99214-25 rendered on March 10, 2021.
2. The fee guidelines for disputed services is found in 28 TAC §134.203.

   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."

   On July 2, 2021, the respondent issued payment of $221.76 for CPT code 99214-25. The respondent noted that the check had cleared; therefore, additional reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due.

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

		8/12/2021
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, 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 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.