TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Donald Martin McPhaul

Respondent Name
Employers Compensation Insurance Co

MFDR Tracking Number
M4-21-2432-01

Carrier's Austin Representative
Box Number 4

DWC Date Received
August 26, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 2, 2021	99204 -25	$285.93	$285.93
	Total	$285.93	$285.93

Requestor's Position

The Doctor had to perform the consult to verify that the patient was a candidate for the DMG/NCV study. This is why a comprehensive medical history, comprehensive examination (ROM) etc., and moderate complexity of decision making are included in the report. Because those components are not required for the study. This is why modifier 25 is added to the consult.

Amount in Dispute: $285.93

Respondent's Position

We are in receipt of your medical fee dispute resolution request regarding DOS 02/2/21; your bill has been submitted for processing.

Response submitted by: EIG Services, Inc.,

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC Rule §127.10 sets out general procedures for designated doctor examinations.

3. 28 TAC §134.203 sets out the billing requirements of professional medical claims.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- T13 – Medical necessity denial. You may submit a request for an appeal/reconsideration no later than 10 months from the date of service.
- 5211 – Nurse audit has resulted in an adjusted reimbursement.
- 5213 – Services are not payable as documentation does not support the services rendered
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.

Issues

1. Is the insurance carrier's denial based on medical necessity supported?

2. What rule is applicable to the fee guideline?

3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of Code 99204 - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and a moderate level of medical decision making. When using time for code selection, 45-59 minutes of the total time is spent on the date of the encounter.

   DWC Rule 127.10 (c) states, "The designated doctor shall perform additional testing when necessary to resolve the issue in question. The designated doctor shall also refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question and the designated doctor is not qualified to fully resolve the issue in question. Any additional testing or referral required for the evaluation is not subject to preauthorization requirements nor shall those services be denied retrospectively based on medical necessity, extent of injury, or compensability in accordance with the Labor Code §408.027 and §413.014, Insurance Code Chapter 1305, or Chapters

10, 19, 133, or 134 of this title (relating to Workers' Compensation Health Care Networks, Agents' Licensing, General Medical Provisions, and Benefits--Guidelines for Medical Services, Charges, and Payments, respectively) but is subject to the requirements of §180.24 of this title (relating to Financial Disclosure).

The insurance carrier's denial is not supported. The disputed service will be reviewed per applicable fee guideline.

2. DWC Rule 134.203 (c) states in pertinent part, to determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. The maximum allowable reimbursement (MAR) is calculated as DWC conversion factor divided by the Medicare conversion factor then multiplied by the physician fee schedule allowable or, 61.17 / 34.8931 x $174.09 = $305.19.

3. The MAR for the disputed service is $305,19. The requestor is seeking $285.93. Insufficient evidence was found to support payment of the disputed service. The requested amount of $285.93 is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Employers Compensation Insurance Co must remit to Donald Martin McPhaul $285.93 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		January 4, 2022
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.