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

General Information

Requestor Name
ASHLEY FERGUSON

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number
M4-22-0499-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
November 8, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 24, 2021	99213	$23.00	$23.00
	Total	$23.00	$23.00

Requestor's Position

"According to the EOB, the carrier did not properly reimburse CPT code 99213 on the claim for DOS 08/02/2021[sic]. When the claim was processed, CPT code 99213 was only reimbursed $92.00. This amount was less than the agreed upon amount for Texas Worker's Comp. Plus, the fee schedule for Texas worker's compensation increased for 2021, as well as the fee schedule for Medicare."

Amount in Dispute: $23.00

Respondent's Position

The Austin carrier representative for New Hampshire Insurance Company is Flahive Ogden & Latson. Flahive Ogden & Latson was notified of this medical fee dispute on November 16, 2021. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

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 §134.203 sets out the fee guideline for professional medical services.

Denial Reasons

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

- P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 90223 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 252- AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE.
- 00663 - REIMBURSEMENT HAS BEEN CALCULATED ACCORDING TO STATE…

Issues

1. Is the Insurance Carrier's denial reason(s) supported?
2. Is the Requestor entitled to additional reimbursement?

Findings

1. The requestor seeks an additional payment of $23.00 for CPT Code 99213 rendered on May 24, 2021. The insurance carrier issued a payment in the amount of $92.00 and denied the remaining balance with denial reason code(s) 00863, 90223, P12, 252 (descriptions provided above.)

2. The fee guidelines applicable to CPT Code 99213 is 28 TAC §134.203.

   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… (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…"

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

   - The 2021 DWC Conversion Factor is 61.17
   - The 2021 Medicare Conversion Factor is 34.8931
   - Per the medical bills, the services were rendered in San Marcos, TX; therefore, the Medicare locality is "Rest of Texas."
   - The Medicare Participating amount for CPT code(s) 99213 at this locality is $89.05.

- Using the above formula, the DWC finds the MAR is $156.11.
- The respondent paid $92.00.
- The requestor seeks an additional payment of $23.00.

3. Per 28 TAC §134.203 (h)(1-2), "…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; (3) fair and reasonable amount consistent with the standards of §134.1 of this title." The DWC finds that the requestor is entitled to a total recommended amount of $23.00.

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. The DWC finds the requester has established that reimbursement of $23.00 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 the Respondent must remit to the Requestor $23.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		March 3, 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.