TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

# Medical Fee Dispute Resolution Findings and Decision

## General Information

**Requestor Name**
Atlas Neurophysiological Assessment

**Respondent Name**
New Hampshire Insurance Co.

**MFDR Tracking Number**
M4-22-0707-01

**Carrier's Austin Representative**
Box Number 19

**DWC Date Received**
December 14, 2021

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| January 11, 2021 | CPT Code G0453 | $854.12 | $0.00 |
| | **Total** | $854.12 | $0.00 |

## Requestor's Position

"We received a payment in the amount of $59.52 for code G0453. In reviewing the Workman's Comp Fee Schedule (Outlined by CMS), we found that we were underpaid in the amount of $830.85 for code G0453 with 13 units."

**Amount in Dispute:** $854.12

## Respondent's Position

**Response Submitted by:**

The Austin carrier representative for New Hampshire Insurance Co is Flahive, Ogden & Latson. Flahive, Ogden & Latson received a copy of this medical fee dispute on December 21, 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 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

Denial Reasons

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

- 00663-Reimbursement has been calculated according to the state fee schedule guidelines.
- P12-Workers' compensation jurisdictional fee schedule adjustment.
- 298-The recommended allowance is based on the value for the professional component of the service performed.
- 4063-Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting.

Issues

1. Is Atlas Neurophysiological Assessment entitled to additional reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $854.12 for CPT code G0453 rendered on January 11, 2021.

   According to the explanation of benefits, the carrier paid $59.52 for CPT code G0453 based upon the fee guidelines.

   The requestor contends "we found that we were underpaid in the amount of $830.85 for code G0453 with 13 units."

   28 TAC §133.307(c)(2)(J) states, "Requests. Requests for MFDR must be legible and filed in the

form and manner prescribed by the division. (2) Health Care Provider or Pharmacy Processing Agent Request. The requestor must send the request to the division in the form and manner prescribed by the division by any mail service, personal delivery, or electronic transmission as described in §102.5 of this title. The request must include: (J) a copy of all medical bills related to the dispute, as described in §133.10 of this chapter (concerning Required Billing Forms/Formats) or §133.500 (concerning Electronic Formats for Electronic Medical Bill Processing) as originally submitted to the insurance carrier in accordance with this chapter, and a copy of all medical bills submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (concerning Reconsideration for Payment of Medical Bills)."

The requestor did not submit a copy of the medical bill to support 13 units billed or that additional reimbursement is due.

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 not established that additional reimbursement is due.

## Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | 03/09/2022<br>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.