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
MCH Professional Care Hospital

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-22-0726-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
December 13, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 20, 2021	73221	$105.88	$97.10
	Total	$105.88	$97.10

Requestor's Position

The requestor did not submit a position statement but did submit a copy of their request for reconsideration that states, "In accordance with the TX WC fee schedule the expected reimbursement for service rendered is $123.29."

Amount in Dispute: $105.88

Respondent's Position

Upon receipt of the MDR requested, the bill was sent for reconsideration. A payment of $105.87 was issued on 12-23-2021. Attached are copies of the EOR and the payment screens for the bill payment issued.

Response submitted by: ESIS

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 billing requirements of professional medical claims.

Denial Reasons

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

- Modifier 26 represents the professional component of services performed
- Charge exceeds Fee Schedule allowance
- HPSA bonus/Incentive pays at 110% of fee schedule allowance
- P12 – Workers compensation jurisdictional fee schedule adjustment
- Additional recommendation is based upon additional supporting documentation received
- A technical Bill Review (TBR) has been performed
- Previous recommended history on DCN(s): 90283262=$17.41

Issues

1. Did the insurance carrier support additional payment was made?

2. What rule is applicable to reimbursement?

3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement of $105.88 for professional services rendered in May 2021. The requestor states an additional payment was made of $105.87. The documentation submitted was an "Interim Review" which was insufficient to support payment. The disputed service will be reviewed per applicable fee schedule.

2. DWC Rule 28 TAC 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. For service categories of Evaluation & Management, when performed in an office setting, the established conversion factor to be applied is date of service annual conversion factor. The maximum allowable reimbursement (MAR) is calculated as the physician fee schedule amount multiplied by the DWC Conversion Factor divided by Medicare Conversion Factor or $65.32 x 61.17/34.8931 = $114.51.

3. The maximum allowable reimbursement is $114.51. The insurance carrier supported payment of $17.41. A balance of $97.10 is due to the requestor.

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 Indemnity Insurance Co of North America must remit to MCH Professional Care Hospital $97.10 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 22, 2022 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.