



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Corey J Mark MD

Respondent Name

Tx Public School WC Project

MFDR Tracking Number

M4-22-0742-01

Carrier's Austin Representative

Box Number 1

DWC Date Received

December 17, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 16, 2020	99213	\$192.00	\$0.00
Total		\$192.00	\$0.00

Requestor's Position

No position statement submitted.

Amount in Dispute: \$192.00

Respondent's Position

After reviewing the information Requestor provided in its Medical Fee Dispute submission, we have concluded that Requestor timely submitted a corrected bill for the services in question on January 28, 2021. In light of this determination, CRF has rescinded its dispute of Requestor's bill and issue payment for the office visit in question.

Response submitted by: Creative Risk Funding

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:

- P12 – Workers' compensation jurisdictional fee schedule adjustment
- W3 – Reconsideration/Appeal

Issues

1. Is the insurance carrier's reduction based on fee schedule adjustment supported?

Findings

1. The requestor is seeking reimbursement of professional medical services rendered in November 2020. The carrier originally denied based on extent of injury. This denial was not upheld and a payment of \$122.40 was issued on January 3, 2022. The requestor did not request to withdraw this dispute after payment, the disputed service will be reviewed per applicable fee guideline.

DWC Rule 134.230 (c) states in pertinent part to determine the Maximum Allowable Reimbursement (MAR) for professional services, system participants shall apply the Medicare payment policies.

The MAR calculation formula is the DWC conversion factor divided by the Medicare Conversion Factor multiplied by the Physician Fee Schedule Allowable or $60.32/36.0896 \times \$73.23$ equals \$122.40.

The insurance carrier provided evidence of a payment in the amount of \$122.40 on January 3, 2022. No additional payment 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 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	_____ March 15, 2022 Date
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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 electrónico CompConnection@tdi.texas.gov.