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

General Information

Requestor Name
Texas Tech University

Respondent Name
Hartford Casualty Insurance Co

MFDR Tracking Number
M4-22-2679-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
August 22, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 7, 2021	99232	$122.00	$121.89
	Total	$122.00	$121.89

Requestor's Position

"Please review the attached FDR request regarding a claim that has been denied as included in another invoice."

Amount in Dispute: $122.00

Respondent's Position

"Our initial response to the above referred medical fee dispute resolution is as follows: we have escalated the bills in question for bill review audit and payment."

Response submitted by: Gallagher Bassett

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 reimbursement guidelines for professional medical services.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another services/procedure that has already been adjudicated
- 48 – the provider billed for a visit on the same day of surgery or withing the follow-up of a previously performed surgery

Issues

1. Did the respondent support their denial?

2. What rule is applicable to reimbursement?

3. Is the requestor entitled to additional payment?

Findings

1. The requestor is seeking reimbursement of professional medical services rendered in December of 2021. The insurance carrier denied the service state the visit was bundled into a previously paid service. Review of the submitted documentation found insufficient evidence to support another service provided on the same day. The insurance carrier's denial is not supported. The disputed service will be reviewed per applicable fee guideline.

2. DWC rule 28 TAC §134.203 states in pertinent part, "(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
- The DWC Conversion Factor divided by the Medicare Conversion Factor is 1.753068658
- Per the medical bill, the services were rendered in Lubbock, TX; therefore, the Medicare locality is "Rest of Texas."
- The Medicare Participating amount for CPT code(s) 99232 at this locality is $69.53.
- Using the above formula, the DWC finds the MAR is $69.53 x 1.753068658 =$121.89.
- The respondent paid $0.00.
- Reimbursement of $121.89 is therefore recommended.

2. The DWC finds that the requestor is entitled to a payment amount of $121.89. This amount 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 respondent must remit to requestor $121.89 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	December 21, 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.