



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

GARY RICHARD WILLIAMS

**Respondent Name**

NEW HAMPSHIRE INSURANCE COMPANY

**MFDR Tracking Number**

M4-22-2813-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

August 30, 2022

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 8, 2021	99204	\$297.89	\$297.89
	<b>Total</b>	\$297.89	\$297.89

### Requestor's Position

"WORK COMP TREATMENT AND SERVICES OFFICE CONSULTATION NO PAYMENT RECEIVED."

**Amount in Dispute:** \$297.89

### Respondent's Position

"The Austin carrier representative for New Hampshire Insurance Co is Flahive Ogden & Latson. Flahive Ogden & Latson was notified of this medical fee dispute on September 7, 2022. 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 (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:

- 90147 & 109 – Claim not covered by this payer/contractor you must send the claim to the correct payer/contractor.
- 90950 – This bill is a reconsideration of a previously reviewed bill allowance amounts reflect any changes the previous payment.
- 193 – Original payment decision is being maintained upon review; it was determined that this claim was processed properly.

### Issues

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

### Findings

1. The requestor seeks reimbursement for CPT Code 99204 rendered on September 8, 2021. The insurance carrier payment with the denial reduction codes indicated above.

28 TAC §134.203(b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

CPT code 99204 is described as "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family."

The insurance carrier did not respond to the DWC060 request. A review of the medical documentation finds insufficient documentation to support the denial reasons raised by the insurance carrier. The DWC finds that the requestor submitted sufficient documentation to support the billing of CPT Code 99204. As a result, the requestor is entitled to reimbursement for the disputed service.

2. 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. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (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 zip code 75247 ; therefore, the Medicare locality is "Dallas."
- The Medicare Participating amount for CPT code 99204 at this locality is \$170.22.
- Using the above formula, the DWC finds the MAR is \$298.41.
- The respondent paid \$0.00.
- The requestor seeks \$297.89, applicable 28 TAC 134.203(h) states that the total reimbursement is the lesser of the maximum allowable reimbursement (MAR) and the billed amount, as a result the requestor is entitled to \$297.89.

The DWC finds that based on the reasons indicated above, the requestor is entitled to reimbursement in the amount of \$297.89. Therefore, 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.

The DWC finds the requester has established that reimbursement of \$297.89 is due.

## Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor \$297.89 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

February 6, 2023  
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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).