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
Ritesh R. Prasad

Respondent Name
Insurance Co of the State of PA

MFDR Tracking Number
M4-23-0190-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 22, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 11, 2022	99214	$334.00	$226.30
	Total	$334.00	$226.30

Requestor's Position

"I marked the procedural guidelines that were met for procedure code 99214 and Dr. Marshall's documentation met all the guidelines, yet Gallagher Bassett denies all these codes."

Amount in Dispute: $334.00

Respondent's Position

"…the provider was not entitled to reimbursement. That remains the carrier's position."

Response submitted by: Flahive, Ogden and Latson

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 fee guideline for professional 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. It was determined that this claim was processed properly.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 150 – Payment adjusted because the payer deems the information submitted does not support the level of service.

Issues

1. Is the insurance carrier's denial supported?

2. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement of professional medical services rendered in April 2022. The insurance carrier denied the disputed service based on the information does not support the level of service.

   Review of the submitted medical bill found the requestor billed code 99214 – "Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter."

   Review of the submitted medical record found under the "Assessment and Plan" a driving evaluation was ordered, medications monitored and refilled, and AWARE Database was reviewed. In addition, review of the DWC 73 found a start time of 10:45 and an end or discharge time of 11:22 for a total of 37 minutes. Based on a medical decision making of a moderate level and a total of 37 minutes spent in the encounter, the insurance carrier's denial

is not supported. The applicable fee guideline is shown below.

2. DWC Rule 134.203 (c)(1) 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, 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 (conversion factor for applicable date of service.)

   The maximum allowable reimbursement (MAR) is calculated as the DWC conversion factor divided by the Medicare conversion factor then multiplied by the physician fee schedule for the location or (62.46/34.6062 x $125.38 (Rest of Texas) = $226.30. 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 $226.30 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	October 28, 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.