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
Peak Integrated Healthcare

Respondent Name
Safety National Casualty Corp

MFDR Tracking Number
M4-23-0371-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
October 13, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 25, 2022	99361-W1	$0.00	$0.00
May 26, 2022	99080-73	$15.00	$15.00
May 26, 2022	99213	$45.50	$45.50
	Total	$60.50	$60.50

Requestor's Position

The requestor did not submit a position statement with this request for MFDR.

Amount in Dispute: $60.50

Respondent's Position

"The carrier's position is that the provider has been reimbursed all of the monies the provider is entitled to."

Response submitted by: Flahive, Ogden & 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 reimbursement guidelines for professional medical services.

3. 28 TAC §129.5 sets out the reimbursement guidelines for work status reports.

Denial Reasons

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

- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 190 – Billing for report and/or record review exceeds (illegible)
- 4083 – Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting

Issues

1. Is the insurance carrier's denial and/or reduction of charges supported?

2. Is the requestor due an additional payment?

Findings

1. The requestor is seeking additional payment for professional medical services rendered in May of 2022. The insurance carrier denied the status report and reduced the payment for code 99213 based on the allowable for services rendered in a facility. Review of the submitted medical bill found the place of service 11 (Office) was used. The insurance carrier's fee calculation based on facility is not supported. The applicable fee guideline is shown below.

   DWC Rule 28 129.5 (j) states in pertinent part, a doctor, delegated physician assistant, or delegated advanced practice registered nurse may bill for, and an insurance carrier shall reimburse, filing a complete Work Status Report required under this section. The amount of reimbursement is $15. 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 current year conversion factor.

The maximum allowable reimbursement (MAR) is calculated as DWC Conversion Factor/Medicare Conversion Factor x Medicare Physician fee schedule for location or $62.46/34.6062 x $92.65 (location Dallas, Texas) = $167.22.

The allowed amount for 99080 -73 is $15.00

The total allowed amount is $182.22. The insurance carrier paid $121.72. An additional payment in the amount of $60.50 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 respondent must remit to requestor $60.50 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	November 15, 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.