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
Arch Insurance Co

MFDR Tracking Number
M4-23-0379-01

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
March 11, 2022	99213	$63.08	$63.08
	Total	$63.08	$63.08

Requestor's Position

The requestor did not submit a position statement with this request for MFDR but did submit a copy of their reconsideration that states in pertinent part, "The above date of services were denied full payment stating, "Workers Compensation Jurisdictional Fee Adjustment." This is incorrect. Please submit for adjudication."

Amount in Dispute: $63.08

Respondent's Position

The Austin carrier representative for Arch Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on October 18, 2022.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available

information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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.

- 309 – The charge for this procedure exceeds the fee schedule allowance
- P12 – Workers' Compensation Jurisdictional fee schedule adjustment

Issues

1. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking additional reimbursement for professional medical services rendered in March, 2022. The insurance carrier reduced the payment amount based on the workers' compensation fee schedule.

   DWC Rule 134.203 (c) 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 date of service applicable fee schedule.

   The Medicare allowed amount for Dallas; Texas is $92.65. This amount is multiplied by the result of dividing the workers' compensation conversion factor by the Medicare conversion factor or 62.46/34.6062 (92.65 x 62.46/34.6062 = $167.22).

The maximum allowed amount is $167.22. The insurance carrier paid $104.14. A balance of $63.08 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 $63.08 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	January 30, 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. 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.