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
M4-23-2245-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
May 9, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 22, 2022	99213	$167.22	$0.00
December 22, 2022	99080-73	$15.00	$0.00
December 22, 2022	99361-W1	$113.00	$0.00
	Total	$295.22	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for medical fee dispute. They did submit a copy of their reconsideration that states, "We disagree that this is a duplicate claim/service. We have not received payment."

Amount in Dispute: $295.22

Respondent's Position

"Attached is a copy of all bills received to date, as well as the corresponding Explanation of Benefits and payment details."

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 Texas Administrative Code §133.307 sets out the guidelines for the resolution of medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services.
4. 28 Texas Administrative Code §129.5 sets out the reimbursement of work status reports.

Denial Reasons

- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 247 – A payment or denial has already been recommended for this service.

Issues

1. What is the rule applicable to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of professional medical services rendered in December 2022. The insurance carrier provided evidence of a payment made on January 25, 2023 in the amount of $295.22 via check number 0185334388. The requestor maintains their request for MFDR.

   DWC 28 TAC §134.203 (c)(1) & (2) states in pertinent parts, (c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. For service categories of Physical Medicine and Rehabilitation, when performed in an office setting, the established conversion factor to be applied is date of service annual conversion factors. 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.

   The following formula represents the calculation of the DWC MAR at §134.203

(c)(1)&(2).

(DWC Conversion Factor ÷ Medicare Conversion Factor) x Medicare Payment = MAR

- 99213 – 62.46/34.6062 x $92.65 (location Dallas, Texas) = $167.22.
- 99080 -73. Reimbursement is $15 per DWC Rule 28 TAC §129.5(j).
- 99361 -W1. Reimbursement is $113.00 per DWC Rule 28 TAC §134.204(e).
- Total MAR = $295.22

2. The total allowable DWC fee guideline is $295.22. The respondent paid $295.22. No additional payment is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has not established payment is due. The amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 29, 2023 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.