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
Alison Walls, PHD

Respondent Name
Pennsylvania Manufacturers Indemnity Co.

MFDR Tracking Number
M4-23-2816-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
July 6, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 30, 2022	96116 - 95	$2.71	$2.71
August 30, 2022	96132 - 95	$3.42	$3.42
August 30, 2022	96133 - 95	$35.42	$35.42
August 30, 2022	96136 - 95	$1.09	$1.09
August 30, 2022	96137 - 95	$5.58	$5.58
	Total	$48.22	$48.22

Requestor's Position

"The carrier has not paid this claim in accordance with compliance with TDI-DWC Rule 133 and 134. The carrier has not responded or has denied this claim in its entirety following our filing of Request for Reconsideration. Therefore, we are filing for Medical Dispute Resolution at this time per Rule 133.307."

Amount in Dispute: $48.22

Respondent's Position

"We are attaching a copy of the provider's initial medical bill and the carrier's EOB dated September 29, 2022. That EOB recommended payment of $3792.52. The payments were based upon the Medical Fee Guidelines. The provider is not entitled to any additional payment."

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 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

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

Findings

1. The insurance carrier issued a payment in the amount of $3,792.58 for professional medical services rendered on August 30, 2022. The requestor seeks an additional payment of $48.22. The insurance carrier reduced the remaining charges with denial reason code P12.

   The requestor appended modifier -95 to the disputed services. Modifier -95 is defined as, "Modifier 95. Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system."

   A review of CMS's list of approved telemedicine services is

   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 or 64.83/33.8872 = 1.91

The physician fee schedules are published by carrier and locality.

The services were provided in zip code 77042, which is Houston, Texas.

The carrier code for Texas is 4412. The locality code for Houston is 18.

Rule §134.203 (h)(1)(2) states in pertinent part, when there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the MAR amount; health care provider's usual and customary charge, unless directed by the Division rule to bill a specific amount.

Date of Service	CPT Code	Units	Billed Amount	MAR	Insurance Paid	Amount Due
August 30, 2022	96116-95	1	$177.17	$188.31	$174.46	$2.71
August 30, 2022	96132-95	1	$245.08	$260.49	$241.66	$3.42
August 30, 2022	96133-95	14	$2661.26	$2,828.61	$2,625.84	$35.42
August 30, 2022	96136-95	1	$83.10	$88.33	$82.01	$1.09
August 30, 2022	96137-95	9	$674.19	$716.61	$668.61	$5.58
		Total	$3840.80	$4,082.35	$3792.58	$48.22

The total allowed amount is $4,082.35.

WC Rule 134.203 (h)(1)(2) states in pertinent part, when there is no negotiated or contracted amount that complies with Labor Code §413.011m reimbursement shall be the least of the MAR amount; health care provider's usual and customary charge.

The health care providers usual and customary charge is $3840.80. The insurance carrier paid $3792.58. The remaining balance is $48.22. 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 Pennsylvania Manufacturers Indemnity Co must remit to Dr. Alison Walls $48.22 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 3, 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.