



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Peak Integrated  
Healthcare

**Respondent Name**

New Hampshire Insurance Co

**MFDR Tracking Number**

M4-25-0087-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

September 11, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 25, 2024	99213	\$185.89	\$52.89
June 25, 2024	99080-73	\$15.00	\$0.00
<b>Total</b>		\$200.89	\$52.89

### Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy a reconsideration request dated August 14, 2024, September 11, 2024 that states, "**Again after reconsideration we were denied payment stating, "workers compensation jurisdictional fee adjust.", this is incorrect. This is a compensable claim and should be paid.**"

**Amount in Dispute:** \$200.89

### Respondent's Position

"The carrier's position that the provider is not entitled to reimbursement."

**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 \(TAC\) §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

- 00663 – Reimbursement has been calculated based on the state guidelines.
- 193/90563 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 4063 – Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting.
- 5283 – Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, provider's contract, or carrier decision.
- P12-1 Workers' compensation jurisdictional fee schedule adjustment.

## Issues

1. Did the insurance carrier make a payment for the disputed services?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

## Findings

1. The information submitted to the Division found a payment of \$148.31 was made on Jul 19, 2024 via check number 0199994066 for date of service June 25, 2024. The requestor is disputing the reduction made due to worker's compensation fee schedule.
2. DWC Rule 28 Texas Administrative Code §134.203(c)(1) states, "...To determine to MAR for professional services, system participants shall apply the Medicare payment policies with minimal modification...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 \$53.68..."

The following formula represents the calculation of the DWC MAR at §134.203 (c)(1) & (2).

$(\text{DWC Conversion Factor} \div \text{Medicare Conversion Factor}) \times \text{Medicare Payment} = \text{MAR}$ . In this instance,  $67.81/33.2875 \times \$91.25 = \$185.89$ .

The requestor is also seeking \$15.00 for code 99808-73. The information referenced above

indicates a payment of \$15.00 was made. As the billed amount was paid in full, no additional payment is recommended.

3. The total allowable DWC fee guideline reimbursement is \$200.89. The insurance carrier paid \$148.31. The balance of \$52.58 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 new Hampshire Insurance Co must remit to Peak Integrated Healthcare \$52.89 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

February 4, 2025

\_\_\_\_\_  
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](http://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](mailto: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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).