



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Eric James Curley

**Respondent Name**

Indemnity Insurance Co of North America

**MFDR Tracking Number**

M4-25-1709-01

**Carrier's Austin Representative**

Box Number 15

**DWC Date Received**

March 20, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 21, 2024	99284	\$243.33	\$62.12
March 21, 2024	12001	\$113.38	0.00
<b>Total</b>		\$356.71	\$62.12

### Requestor's Position

"We request that the reimbursement for these CPT codes be adjusted to reflect the standard fair market value for out-of-network emergency care."

**Amount in Dispute:** \$356.71

### Respondent's Position

"We have determined that no additional is due. Here are the calculations. The EOB is attached.."

**Response submitted by:** Broadspire

### 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

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

- D00 – Based on further review, no additional allowance is warranted.
- G14 – Pricing is calculated based on the medical professional fee schedule facility site of service value.
- J16 – This procedure code was ranked as the primary service when considered for multiple procedure reduction. As a result no reduction was taken.
- J42 – Pricing for this service is based on the professional component because the technical component for this service has been priced.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

### Issues

1. What services are in dispute?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

### Findings

1. The documents submitted with this request for MFDR included a professional medical bill (CMS 1500) and an institutional bill (UB04). The services listed on the CMS 1500 were rendered by the requestor, Eric Curley, MD. These are also the codes listed on the DWC060 as being in dispute. The fee calculation is shown below.
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).

(DWC Conversion Factor ÷ Medicare Conversion Factor) x Medicare Payment = MAR. In this instance,

- Code 99284 - Emergency department visit for the evaluation and management of a patient (CMS fee schedule facility only) 85.12/33.2875 x \$119.45 (CMS fee schedule for location) = \$305.45. Insurance carrier paid \$243.33. Additional payment in the amount of \$62.12 is due to the requestor.
- Code 12001 - 85.12/33.2875 x \$44.34 = \$113.38 (insurance carrier paid this amount)

3. A balance of \$62.12 is due to the requestor.

### Conclusion

For the reasons stated above, the DWC finds that the requestor 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 Indemnity Insurance Co of North America must remit to Eric James Curley, MD \$62.12 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

June 23, 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).