



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Texas Back Institute

Respondent Name

Ace American Insurance Co

MFDR Tracking Number

M4-06-7293-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

July 31, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The audit company (Accumed) has applied the Multiple Procedure Rule incorrectly."

Amount in Dispute: \$951.58

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Triad, the network that was involved in the reduction of this medical bill in 2006 is no longer in business. Therefore, Respondent is sending the medical bill for the date of service 12/28/05 to their audit company for reprocessing."

Response Submitted by: Downs & Stanford PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 28, 2005	Surgical Services	\$951.58	\$860.85

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §1334.202 sets out fee guidelines for professional medical services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 42 – Charges exceed our fee schedule or maximum allowable amount
 - W4 – Previous recommendation(s) will stand

Issues

- Did the requestor support charges billed per Division guidelines?
- Did the respondent support reason for reduction of payment?
- Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.202(d) states "in all cases, reimbursement shall be the least of the: (1) MAR amount as established by this rule; (2) health care provider's usual and customary charge; or, (3) health care provider's workers' compensation negotiated and/or contracted amount that applies to the billed service(s)." In regards to 42 – "Charges exceed our fee schedule or maximum allowable amount", the services in dispute were reduced in part this explanation code. No documentation was provided to support that a reimbursement rate was negotiated between the workers' compensation insurance carrier ACE and the health care provider prior to the services being rendered, therefore 28 Texas Administrative Code §134.202(d)(3) does not apply. The disputed services will be reviewed per applicable rules and fee guidelines.
2. Per 28 Texas Administrative Code §134.203 (b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided..."

Date of Service	Submitted Code	Submitted Charge	MAR Physician fee schedule allowable for Plano TX x 125%	Carrier Paid
December 28, 2008	22845	1015.66	772.35 x 125% = \$965.43	482.72
December 28, 2008	22851	563.15	428.04 x 125% = \$535.05	267.53
December 28, 2008	20937	233.65	177.00 x 125% = \$221.25	110.63
	Total	\$1,812.46	\$1,721.73	\$860.88

3. The total MAR for the services in dispute is \$1,721.73. The Carrier previously paid \$860.88. The remaining balance of \$860.85 is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$860.85.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$860.85 plus applicable accrued interest per 28 Texas Administrative Code §134.803 due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

Date

August 21, 2014

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

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