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
Richard G. Buch

Respondent Name
TX Assoc of Counties RMP

MFDR Tracking Number
M4-07-5851-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
May 7, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Extensive procedure resulting in use of 22 modifier. Documentation and letter sent giving details based on extensive scarring making procedure difficult. 20-30% typically allowed for extensive px."

Amount in Dispute: $ "?" Per DWC 60, Part V

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Nothing in the Act or Rules supports the Provider's assertion that reimbursement at 145 – 155% of Medicare is appropriate. As the Carrier reimbursed the Provider the MAR based on the Medical Fee Guideline, the reimbursement provided is fair and reasonable. No additional reimbursement is due."

Response Submitted by: J T Parker & Associates LLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 8, 2006	23472-22	$0.00	$0.00

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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202 sets out fee guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 45 – Charge exceed your contracted/legislated fee arrangement
   - W3 – Additional payment made on appeal/reconsideration

Issues

1. Did the requestor support request for additional payment?

2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Labor 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 45 – "Charge exceed your contracted/legislated fee arrangement." No documentation was found to support this reduction in payment. Further documentation finds the carrier paid the previous reduction based on the contract in an adjustment for the amount of $95.90 on August 30, 2006. The payment brings total to Maximum allowable reimbursement (Physician fee schedule allowable for Arlington, TX x 125%) or $1,534.42 x 125% = 1,918.03. This payment complies with 28 Texas Labor Code §134.202(c)(1) which states, "for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%."
2. The requestor's rationale for increased reimbursement from the Table of Disputed Services asserts that, "Extensive procedure resulting in use of 22 modifier. Documentation and letter sent giving details based on extensive scarring making procedure difficult. 20-30% typically allowed for extensive px."
    - The requestor does not discuss or explain how payment of an additional 20 - 30% would result in a fair and reasonable reimbursement.
    - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
    - The requestor did not submit documentation to substantiate the duration of the procedure performed nor to support the duration of a typical procedure as a basis for comparison.
    - The requestor did not submit documentation of the average work effort, practice expenses, operative time, technical difficulty and/or complexity of follow-up required to provide a typical unconstrained total shoulder arthroplasty as a basis of comparison to demonstrate how the services performed were significantly greater than usually required.
    - The requestor did not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.
    - The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
    - The requestor did not submit nationally recognized published studies, published Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments to support the proposed methodology.

3. The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		August 21, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

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.