**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**
Robert Josey

**Respondent Name**
United States Fire Insurance Co

**MFDR Tracking Number**
M4-07-6337-01

**Carrier's Austin Representative**
Box Number 53

**MFDR Date Received**
May 29, 2007

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Authorization from carrier and treating physician was obtained prior to visit. Charges denied for no authorization."

**Amount in Dispute:** $525.67

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Payment denied/reduce for absence of, or exceeded referral."

**Response Submitted by:** Hoffman Kelley LLP

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| September 20, 2006 | 99243, 72110, 99080 | $525.67 | $239.43 |

## *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 §127.10 sets out duties of designated doctors.
3. 28 Texas Administrative Code §134.202 sets out fee guidelines for professional medical services.
4. 28 Texas Administrative Code §129.5 sets reimbursement amount for work status reports.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 51 – Payment denied/reduced for absence of, or exceeded referral
   - 45 – Charges exceed your contracted/legislated fee arrangement

**Issues**

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. Was prior authorization required per Division guidelines?
3. Is the requestor entitled to reimbursement?

**Findings**

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. Per 28 Texas Administrative Code§127.10 9(c). "The designated doctor shall perform additional testing when necessary to resolve the issue in question. The designated doctor shall also refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question and the designated doctor is not qualified to fully resolve the issue in question. Any additional testing or referral required for the evaluation is not subject to preauthorization requirements nor shall those services be denied retrospectively based on medical necessity, extent of injury, or compensability in accordance with the Labor Code §408.027 and §413.014, Insurance Code Chapter 1305, or Chapters 10, 19, 133, or 134 of this title (relating to Workers' Compensation Health Care Networks, Agents' Licensing, General Medical Provisions, and Benefits--Guidelines for Medical Services, Charges, and Payments, respectively) but is subject to the requirements of §180.24 of this title (relating to Financial Disclosure). Any additional testing or referral examination and the designated doctor's report must be completed within 15 working days of the designated doctor's physical examination of the injured employee unless the designated doctor receives division approval for additional time before the expiration of the 15 working days. If the injured employee fails or refuses to attend the designated doctor's requested additional testing or referral examination within 15 working days or within the additional time approved by the division, the designated doctor shall complete the doctor's report based on the designated doctor's examination of the injured employee, the medical records received, and other information available to the doctor and indicate the injured employee's failure or refusal to attend the testing or referral examination in the report. Review of the submitted documentation finds;
    a. Referral made from treating physician (Dr. Steve Minors) to referral physician (Dr. Robert Josey) for evaluation and treatment of injured workers lumbar region
    b. Physicians note from exam done September 20, 2006 where exam and testing performed
    c. Texas Workers' Compensation Work Status Report dated September 20, 2006.

   Based on the above, the Carrier's denial is not supported.
3. 28 Texas Administrative Code §134.202(c)(1) states in pertinent part, "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%.The Maximum Allowable Reimbursement will be calculated as follows;

| Date of Service | Submitted Code | Billed Amount | MAR Physician fee schedule amount for Austin Tx multiplied by 125% |
|---|---|---|---|
| September 20, 2006 | 99243 | $350.00 | $125.14 x 125% = $156.43 |
| September 20, 2006 | 72110 | $155.67 | $54.40x 125% = $68.00 |
| September 20, 2006 | 99080 | $20.00 | $15.00 (per 28 TAX 129.5(i) found below) |
| | | $525.67 | $239.43 |

28 Texas Administrative Code §129.5 (i) Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15.

The total MAR for the disputed services is $239.43. The carrier previously paid $0.00 leaving a balance due to the requestor of $239.43. This amount is recommended.

**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 $239.43.

## *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 $220.30 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

**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**.