



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

Ergonomic Rehabilitation of Houston

**Respondent Name**

Texas Mutual Insurance Co

**MFDR Tracking Number**

M4-07-7572-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

July 23, 2007

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Our charges for the disputed dates of service were denied due to no pre-authorization for units over 45 minutes. Rule 134.202(c) states to determine the maximum allowable reimbursement (MARs) for professional services system participants shall apply the Medicare payment policy. "

**Amount in Dispute:** \$203.64

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** Written notice of medical fee dispute received however, no position statement was submitted.

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 1 – 21, 2007	97110	\$203.64	\$203.64
February 7, 2007	97002		

#### 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 §133.202 sets out the fee guideline for professional medical services.
- The name of injured employee and date of injury on submitted DWC 60 did not match the injured employee name on the submitted medical claim, explanation of benefits, requestor's position statement or other submitted documentation. This review applies to injured worked referenced on the above mentioned documentation.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 797 – Denied for lack of preauthorization or preauthorization denial in accordance with the network contract
  - 790 – This charge was reimbursed in accordance to the Texas medical fee guideline
  - W4 – No additional reimbursement allowed after review of appeal/reconsideration

**Issues**

1. Did the requestor receive authorization for level of service provided?
2. Was the reduction taken for CPT Code 97002 in compliance with Division fee guidelines?
3. Is the requestor entitled to reimbursement?

**Findings**

1. The carrier denied the disputed services as 797 – “Denied for lack of preauthorization or preauthorization denial in accordance with the network contract.” Review of the submitted documentation finds
  - a. Procedure code 97110 authorized from 01/30/07 to 03/09/07 for a total of 12 visits
  - b. 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)." No documentation was found to support a network contract.

The carrier's denial is not supported as the authorization was per “visit” not per unit. No documentation was found to support a network contract. The disputed services will be reviewed per applicable Division rules and fee guidelines.

2. Per 28 Texas Administrative Code §134.202 (c) states, “To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) 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 (MAR) will be calculated as follows;

Date of Service	Submitted Code	Submitted Charge	MAR Physician Fee Schedule allowable for Houston, Texas x 125%
February 1, 2007	97110	\$180.00	\$27.15 x 125% = \$33.94
February 5, 2007	97110	\$180.00	\$27.15 x 125% = \$33.94
February 7, 2007	97110	\$135.00	\$0 amount in dispute per DWC 60
February 7, 2007	97002-59	\$65.00	\$0 amount in dispute per DWC 60
February 12, 2007	97110	\$180.00	\$27.15 x 125% = \$33.94
February 14, 2007	97110	\$180.00	\$27.15 x 125% = \$33.94
February 16, 2007	97110	\$180.00	\$27.15 x 125% = \$33.94
February 21, 2007	97110	\$180.00	\$27.15 x 125% = \$33.94
Total		\$1,280.00	\$203.64

3. The total MAR for the services in dispute is 203.64. 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 \$203.64.

**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 \$203.64 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
August 21, 2014  
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.**