



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

PAIN AND RECOVERY CLINIC

Respondent Name

ACE AMERICAN INSURANCE CO

MFDR Tracking Number

M4-08-0289-02

Carrier's Austin Representative

Box Number 15

MFDR Date Received

SEPTEMBER 14, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please find enclosed a copy of the E.O.B.s (denial), the medical bills (RFR), the supporting documentation & the CCH decision dated 8/4/08."

Amount in Dispute: \$65.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "ESIS respectfully disputes any indemnity benefits, medical benefits and an injury in the course and scope of employment."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 6, 2007	CPT Code 72100-WP	\$65.00	\$48.75

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 §133.305 sets forth general provisions regarding dispute of medical bills.
- 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
- 28 Texas Administrative Code §134.202, titled *Medical Fee Guideline* effective for professional medical services provided on or after August 1, 2003, set out the reimbursement guidelines.
- 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 880-101-Allownce Denied: The claim is being disputed by the carrier/adjuster 100%
 - 880-197-Denial Code E-Entitlement to Benefits 100%.
 - 218-Based on entitlement to benefits (NOTE: To be used for workers compensation only)
 - 214-Workers compensation claim adjudicated as non-compensable. This payer not liable for claim or

service/treatment. (NOTE: To be used for workers compensation only)

- 880-212-Claim denied 100%.
- W11-Entitlement to benefits. Not finally adjudicated.
- In response to a provider inquiry, we have re-analyzed this bill and arrived at the same recommended allowance.

Issues

1. Has the compensability/liability/extent of injury issue been resolved?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor filed a dispute with the Medical Fee Dispute Resolution section at the Division on September 14, 2007.

According to 28 Texas Administrative Code §133.305(a)(4), a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) goes on to state that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e) (3) (H) requires that if the carrier has raised a dispute pertaining to compensability, extent of injury, or liability for the claim, the Division shall notify the parties of the review requirements pursuant to §124.2 of this title, and will dismiss the request until those disputes have been resolved by a final decision, inclusive of all appeals. The appropriate dispute process for unresolved issues of compensability, extent and/or liability requires filing for a Benefit Review Conference pursuant to 28 Texas Administrative Code §141.1 prior to requesting medical fee dispute resolution. No documentation was submitted to support that the issue(s) of compensability, extent and/or liability have been resolved as of the undersigned date.

The August 4, 2008 Contested Case Hearing Decision and Order found that "Claimant sustained a compensable injury on March 5, 2007, and the carrier was ordered to pay benefits in accordance with the decision, the Texas Workers' Compensation Act, and the Commissioner's Rules. The Division concludes that the compensability/liability/extent of injury issue has been resolved.

2. 28 Texas Administrative Code §134.202(b) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section."

CPT Code 72100-WP is defined as "Radiologic examination, spine, lumbosacral; 2 or 3 views." The requestor appended modifier 'WP-Whole Procedure' to the code.

Per Rule 134.202(b), the maximum allowable reimbursement, (MAR) is determined by locality. A review of Box 32 on CMS-1500 indicates that the zip code 77076 is the locality. This zip code is located in Houston, Texas.

28 Texas Administrative Code §134.202(c)(1) states "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: "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 Medicare allowable for CPT code 72100 in Houston, Texas is \$39.00. Per 28 Texas Administrative Code §134.202(c)(1) this amount is multiplied by 125% equals a MAR of \$48.75. The difference between the MAR and amount paid is \$48.75. As a result, the amount ordered is \$48.75.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$48.75.

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 \$48.75 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature


Signature

Elizabeth Pickle, RHIA
Medical Fee Dispute Resolution Officer

05/09/2014
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.

