



**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**

San Antonio Accident/Injury Care

**Respondent Name**

Dolgencorp of Texas Inc

**MFDR Tracking Number**

M4-08-0506-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

September 20, 2007

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Procedure was approved."

**Amount in Dispute:** \$157.62

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** It appears based on the available information that the charges were reduced in accordance with the fee guidelines.

**Response Submitted by:** Flahive Ogden & Latson

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 21 – 24, 2007 June 4 – 11, 2007	97124	\$157.62	\$150.36

**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 the fee guidelines for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out guidelines for prospective and concurrent review of health care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 131 – Claim specific negotiated discount
  - 397 – Allowance is based on utilization review pre-authorization.
  - 151 – Payment adjusted because the payer deems the information submitted does not support this many services.

**Issues**

1. Are the services in dispute subject to contract?

2. Did the requestor support additional payment is due?
3. What is the applicable rule in determining fee guidelines?
4. Is the requestor entitled to reimbursement?

### **Findings**

1. 28 Texas Administrative Code (d) 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). The carrier denied the disputed charges as 131 - "Claim specific negotiated discount." No documentation was provided in regards to support that a reimbursement rate was negotiated between the worker's compensation insurance carrier and the health care provider prior to the services being rendered; therefore 28 Texas Administrative Code §134.202(d)(3) does not apply. The services in dispute will we reviewed per applicable fee guidelines.
2. Per 28 Texas Administrative Code §134.600(p) "Non-emergency health care requiring preauthorization includes: (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to: (i) Modalities, both supervised and constant attendance; (ii) Therapeutic procedures, excluding work hardening and work conditioning; (iii) Orthotics/Prosthetics Management; (iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code;" Review of the submitted documentation finds;
  - a. Notice of Utilization Review Decision 104958– "Certified Service(s): Physical therapy 3 x 3 weeks 05/15/2007 to 06/15/2007."

The Utilization Review Decision states "physical therapy" and does not distinguish by CPT code services or the number of units per procedure that are approved or denied. Therefore, the services denied as, 397 – "Allowance is based on utilization review pre-authorization" is not supported. The services in dispute will be reviewed per applicable fee guidelines.

28 Texas Labor Code §134.202(b) (adopted to be effective January 5, 2003, 27 TexReg 4048 and 12304), states in pertinent part, "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. Review of the submitted medical claim finds the following;

- b. Code 95851 has a description of: "Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)."
  - c. Review of the medical documentation finds notes to support massage therapy was done on each of the dates of service in dispute.
3. 28 Texas Labor Code §134.202(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 (MAR) is  $\$20.05 \times 125\% = \$25.06$  for each date of service (6) = \$150.36.
4. The total recommended payment for the services in dispute is \$150.36. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$150.36. This amount is 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 \$150.36.

### ***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 \$150.36, 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 28, 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.**