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
ALTA VISTA HEALTHCARE LP

Respondent Name
CITY OF SAN ANTONIO

MFDR Tracking Number
M4-08-5399-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
APRIL 18, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Pre-auth#: AP1379971012"

Amount in Dispute: $24.74

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor has agreed to withdraw their request as payment is being processed and payment will satisfy all disputed issues."

Response Submitted by: Harris & Harris

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 28, 2007	CPT Code 90806	$24.74	$24.74

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, effective August 1, 2003, sets the reimbursement guidelines for the disputed services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 11-The diagnosis is inconsistent with the procedure.
   - W4-No additional reimbursement allowed after review of appeal/reconsideration.

Issues

Is the requestor entitled to additional reimbursement?

Findings

According to the respondent's position summary the services in dispute were going to be paid and the dispute

would be resolved. On May 6, 2014, the Division contacted the requestor to verify that services were paid and if they remained in dispute. The requestor's representative indicated that on December 30, 2008 they received a payment of $83.57 and they were still seeking the balance owed. The difference between original amount of $108.31, less payment resulted in $24.74 in dispute.

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."

Per Rule 134.202(b), the MAR is determined by locality. A review of Box 32 on CMS-1500 indicates that the zip code 77030 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 90806 in San Antonio, Texas is $86.65. Per 28 Texas Administrative Code §134.202(c)(1) this amount is multiplied by 125% equals a MAR of $108.31. The difference between the MAR and amount paid is $24.74. As a result, the amount ordered is $24.74.

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 $24.74.

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 $24.74 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	05/08/2014 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.