



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

KILLEEN INJURY CLINIC

Respondent Name

FEDERATED SERVICE INSURANCE CO

MFDR Tracking Number

M4-10-5299-02

Carrier's Austin Representative

Box Number 01

MFDR Date Received

AUGUST 27, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Enclosed are copies of the EOB's, claims and supporting documentation. The insurance carrier has denied payment for these claims stating the back injury is unrelated to the workers injury."

Amount in Dispute: \$528.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 9, 2009	CPT Code 99204 New Patient Office Visit	\$201.79	\$201.57
December 14, 2009	CPT Code 99214 Established Patient Office Visit	\$125.00	\$125.00
January 13, 2010	CPT Code 97530-59 Therapeutic Activities	\$41.69	\$41.69
January 13, 2010	CPT Code 97110-59 (X4) Therapeutic Exercise	\$159.88	\$159.88
Total		\$528.36	\$528.14

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 a medical fee dispute.
- 28 Texas Administrative Code §134.203 effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
- The services in dispute were reduced/denied by the respondent with the following reason codes:

- 191-Not a work related injury/illness and thus not the liability of the workers' compensation carrier.
- 229-Procedure does not appear related to the injury and/or diagnosis. We will re-evaluate this charge upon receipt of clarifying information.
- 96-Non-covered charge(s).
- Back injury is not related to the workers compensation injury of 7/16/09.
- The provider is requesting reconsideration and additional payment for the above charge, this office visit charge is not related to the patients work injury of 7/16/09. Per Marjorie B. the documentation shows that the patient was seen for low back pain. Back injury is not related to the patient work injury of 7/16/09. The provider will need to take this matter to medical dispute resolution for further disposition.
- The provider is requesting reconsideration and additional payment for the above charge. This charge continues to be denied, the documentation does not support the diagnosis code. We will reconsider when supporting documentation is received.

Issues

1. Does a compensability issue exist?
2. Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the carrier denied reimbursement for the services in dispute based upon reason codes "191," "229" and "96." The parties to the dispute reached an agreement that the low back injury was compensable; therefore, a compensability issue does not exist.

reduction; therefore, the disputed services will be reviewed per applicable Division rules and guidelines.

2. 28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2009 DWC conversion factor for this service is 53.68.

The Medicare Conversion Factor is 36.0666

Review of Box 32 on the CMS-1500 the services were rendered in Killeen, Texas; therefore, the Medicare participating amount is based upon the locality of "Rest of Texas".

Using the above formula, the Division finds the following:

Code	Medicare Participating Amount	MAR	Amount Paid	Amount Due
99204	\$135.43	\$201.57	\$0.00	\$201.57
99214	\$87.69	\$130.51, requestor is seeking \$125.00	\$0.00	\$125.00

The 2010 DWC conversion factor for this service is 54.32.

The Medicare Conversion Factor is 36.8729

Using the above formula, the Division finds the following:

Code	Medicare Participating Amount	MAR	Amount Paid	Amount Due
97530	\$29.82	\$43.93, requestor is seeking \$41.69	\$0.00	\$41.69
97110(X4)	\$27.81	\$40.97 X 4 = \$163.88, requestor is seeking \$159.88	\$0.00	\$159.88

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 \$528.14.

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 \$528.14 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

Date

04/11/2014

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.