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 and Address

KEN M KORTHAUER
601 ROCKMEAD DRIVE
KINGWOOD TX 77339

Respondent Name
New Hampshire Insurance Co

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-12-0463-01

MFDR Date Received
October 12, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier paid procedure under a non fac-setting when this should be paid as a facility."

Amount in Dispute: $54.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill was priced correctly, allowing CPT 99222 at $214.98 for date of service 06/17/2011 for services performed in the Houston, TX GPCI location. Based on Medicare's Physician Fee Schedule the values for both the facility and non-facility reimbursement are the exact same."

Response Submitted by: Chartis, 4100 Alpha Road, Ste 700, Dallas, Texas 75244

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 17, 2011	Physician Services	$54.90	$54.90

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 a medical fee dispute.
2. 28 Texas Administrative Code § 134.203 sets out the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - 16 – Duplicate claim/service

Issues

1. Did the requestor support services provided at a facility?
2. What is the applicable rule that determines Maximum Allowable Reimbursement (MAR)?
3. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted medical bill finds the requestor used place of service, "61- Comprehensive Inpatient Rehabilitation Facility""on Centers for Medicare and Medicaid Services 1500, Line, 24B. Therefore, the Division finds the requestor is correct in stating the Facility Based DWC Conversion Factor should be used in the calculation of the MAR.
2. 28 Texas Administrative Code §134.203(c) is the applicable division fee schedule for calculation of the maximum allowable reimbursement for the services in dispute. For services in 2011, the maximum allowable reimbursement = (TDI-DWC Conversion Factor / Medicare CONV FACT) x Facility Price or: (68.47 / 33.9764) x $133.92 = $269.88. The insurance carrier previously paid $214.98 leaving a balance due to the requestor of $54.90. This amount is recommended.
3. Review of the submitted documentation finds that the requestor is due additional reimbursement.

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 $54.90.

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 $54.90 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	February , 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.