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

EMERGENCY PHYSICIANS OF CENTRAL TEXAS
PO BOX 2283
MANSFIELD TX 76063

Respondent Name
New Hampshire Insurance Co

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-12-0937-01

MFDR Date Received
November 17, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to the explanation of review from Sedgwick CMS, CPT 12013 was under-allowed at $97.85. Per the 2011 Texas Workers Compensation Rest of Texas Fee Schedule the allowable rate is $146.07. We are asking for the difference of $48.22 to be paid on this CPT. On CPT 99282 the was over-allowed at $92.97. Per the 2011 Texas Workers Compensation ROT Fee Schedule the allowable rate is $63.91. Please reprocess this CPT less $29.06"

Amount in Dispute: $19.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Respondent notified of medical fee dispute however, no written response submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 25, 2011	Emergency Services	$19.16	$19.16

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 outs the reimbursement guidelines for professional medical services.0
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 18 – DUPLICATE CLAIM/SERVICE
   - 247 – A PAYMENT OR DENIAL HAS ALREADY BEEN RECOMMENDED FOR THIS SERVICE
   - 56 – SIGNIFICANT, SEPARATELY IDENTIFIABLE E/M SERVICE RENDERED
   - 76 – BILLING IS GREATER THAN SURGICAL SERVICE FEE
   - 802 – CHARGE FOR THIS PROCEDRUE EXCEEDS THE OPPS SCHEDULE ALLOWANCE

- 981 – SERVICE PROVIDED IN A DESIGNATED WORKERS' COMPENSATION UNDERSERVED AREA
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT

Issues

1. Did the carrier process the disputed services in compliance with applicable division fee schedule?
2. Is the requestor entitled to reimbursement?

Findings

1. 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:

Code	MAR Calculation	Units	Allowable
12013	(68.47 x 33.9764) x 72.48	1	$146.06
99282	(68.47 x 33.9764) x 39.81	1	$80.23
		Total	$226.29

2. The total allowable for the disputed services is $226.29. The carrier paid $190.82. The requestor is seeking $19.16 this amount is recommended.

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 $19.16.

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 $19.16 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.