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

WRIGHT W SINGLETON MD
121 NE LOOP 820 STE 100
HURST TX 76053

Respondent Name
Sentry Insurance a Mutual Co

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-12-2143-01

MFDR Date Received
February 14, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please review documents that support that the claim was filed on time and with the appropriate codes and modifiers."

Amount in Dispute: $281.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…when both a client and the provider have opted into HCN, the claim will pay according to the providers WC rate, this provider was not opt in for it."

Response Submitted by: Sentry Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 5, 2011	Professional Services	$281.28	$160.20

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. 28 Texas Administrative Code §133.4 sets our guidelines requirements regarding written notification to health care providers of contractual agreements for informal and voluntary networks.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee
   - B14 – Only one visit or consultation per physician per day is covered

Issues

1. Did the respondent support the insurance carrier's reasons for reduction or denial of services?
2. What is the applicable rule for determining reimbursement for the disputed services?

Findings

1. The insurance carrier reduced or denied disputed services with reason code B14 – "Only one visit or consultation per physician per day is covered." The carrier provided no supporting documentation that one visit was paid. Also, 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute. Further review of the TX COMP, ClaimNetworkSummary, finds this injured worker did not enter into First Health TX HCN until 03/29/2012 after the date of service in dispute. The carrier's denial is not supported.
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 Non-Facility Price or
   (54.54 / 33.9764) x 99.80 = $160.20

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 $160.20.

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 $160.20 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	January 23, 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.