



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH OF FORT WORTH
3255 W PIONEER PARKWAY
ARLINGTON TX 76013

Respondent Name

Old Republic Insurance Co

Carrier's Austin Representative Box

Box Number 44

MFDR Tracking Number

M4-13-1641-01

MFDR Date Received

February 27, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have found in this audit they have not paid what we determine is the correct allowable per the Medicare fee schedule for the following HCPC's:"

Amount in Dispute: \$86.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received however, no position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 19, 2012	97750	\$86.06	\$0.00

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 §134.204 sets guidelines for workmen's compensation specific services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W1 – Workers Compensation State Fee Schedule Adjustment
 - 309 – The charge for this procedure exceeds the fee schedule allowance
 - 193 – Original payment decision is being maintained.

Issues

1. Did the requestor submit the disputed service per Division guidelines?

2. Is the requestor entitled to reimbursement?

Findings

1. Procedure code 97750, service date March 19, 2012, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.45. The practice expense (PE) RVU of 0.47 multiplied by the PE GPCI of 0.979 is 0.46013. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.826 is 0.02478. The sum of 0.93491 is multiplied by the Division conversion factor of \$54.86 for a MAR of \$51.29. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at \$51.29. The PE reduced rate is \$46.24 at 5 units is \$231.20. The total is \$282.49.

Requestor submitted a total of 8 units. 28 Texas Administration Code §134.204(g) states in pertinent part, "Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test." Therefore, the Division finds only 6 units are payable based on Division guidelines.

2. The total allowable reimbursement for the services in dispute is \$282.49. This amount less the amount previously paid by the insurance carrier of \$307.74 leaves an amount due to the requestor of \$0.00. No additional reimbursement can be 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 \$0.00.

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 \$0.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	March , 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.