



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

Kirt Repp DC

Respondent Name

Wal Mart Associates Inc

MFDR Tracking Number

M4-13-1791-01

Carrier's Austin Representative

Box Number 53

MFDR Date Received

March 14, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are filing for MDR at this time, regarding our 03-19-2012 electrodiagnostic service, due to the fact that the insurance carrier did not adjudicate the "Request for Reconsideration" as required by current rule. The reconsideration was faxed on 02-19-13 via verified carrier fax number with no response."

Amount in Dispute: \$3,525.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the attached Amended EOB recommending an allowance in the amount of \$1,151.30."

Response Submitted by: Hoffman Kelley LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 19, 2012	Professional Services	\$3,525.00	\$95.00

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services provided in the Texas workers' compensation system.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W1 – Workers Compensation State Fee Schedule Adjustment
 - 225 – Payment of interest/Penalty to Provider
 - 309 – The charge for this procedure exceeds the fee schedule allowance
 - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
 - 906 – In accordance with Clinical based coding edits (National Correct Coding Initiative/outpatient code

editor). Component code of comprehensive medicine. Evaluation and Management Services Procedure (900000-99999) has been disallowed.

Issues

1. Did the carrier calculate Maximum Allowable Reimbursement in line with Division rules?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(c) states in pertinent part, "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" *applicable year Texas Department of Insurance / Workman's Compensation or for 2012 (54.86 / 34.0376)*. Review of the submitted charges is found below;

Code	Charge	Units	MAR	Insurance Paid
99202	\$170.00	1	$(54.86 / 34.0376) \times \text{Non-Facility Price or } \$72.68 \times 1 \text{ unit} = \117.14	\$234.28
95860	\$375.00	1	$(54.86 / 34.0376) \times \text{Non-Facility Price or } \$96.30 \times 1 \text{ unit} = \155.21	\$310.42
95803	\$1,180.00	4	$(54.86 / 34.0376) \times \text{Non-Facility Price or } \$75.41 = \$121.54 \times 4 \text{ units} = \486.16	\$486.16
95904	\$1,800.00	8	$(54.86 / 34.0376) \times \text{Non-Facility Price or } \$56.98 = \$91.84 \times 8 \text{ units} = \734.70	\$367.36
TOTAL	\$3,525.00		\$1,493.22	\$1,398.22

2. Review of the submitted documentation finds that additional reimbursement is recommended based on provisions of Division rules and guidelines. The total Maximum Allowable Reimbursement (MAR) is \$1,493.22. The insurance carrier paid \$1,398.22. The balance of \$95.00 is recommended for the requestor.

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 \$95.00.

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 \$95.00 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

June , 2014
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.