**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**
Nueva Vida Behavioral Health Associates

**Respondent Name**
Hartford Insurance Company

**MFDR Tracking Number**
M4-13-1981-01

**Carrier's Austin Representative**
Box Number 47

**MFDR Date Received**
April 5, 2013

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Carrier has accepted the knee, head, and thoracic as the compensable injury and is directed to pay all claims related to the compensable injury."

**Amount in Dispute:** $660.00

## *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 |
|---|---|---|---|
| July 28, 2012 | 90801 | $660.00 | $237.04 |

## *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 medical fee disputes.
2. 28 Texas Administrative Code §133.240 sets out the procedures for medical payments and denials.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 14 – 146 – Diagnosis was invalid for the date(s) of service reported

**Issues**

1. Did the requestor submit the claim in compliance with Division Rules?
2. Is the requestor entitled to reimbursement?

**Findings**

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged, received on April 17, 2013. The insurance carrier did not submit a response for consideration in this review. Per the Division's former rule at 28 Texas Administrative Code §133.307(d)(1), effective May 25, 2008, 33 *Texas Register* 3954, "If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information." Accordingly, this decision is based on the available information.
2. Per 28 Texas Administrative Code §133.240(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section and (c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies…" Review of the submitted medical claim finds;
   - The medical bill contained three diagnosis codes, 719.46 (Pain in joint, lower leg), 847.1 (Thoracic sprain and strain were found to valid codes. The disputed services will be reviewed based on these valid codes.
   - Procedure code 90801, service date July 28, 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 2.8 multiplied by the geographic practice cost index (GPCI) for work of 1 is 2.8. The practice expense (PE) RVU of 1.57 multiplied by the PE GPCI of 0.912 is 1.43184. The malpractice RVU of 0.11 multiplied by the malpractice GPCI of 0.809 is 0.08899. The sum of 4.32083 is multiplied by the Division conversion factor of $54.86 for a MAR of $237.04.
   - The units billed on the medical claim was three however, the Medically Unlikely Edits in affect for this code only allows payment of one unit.
3. The total allowable reimbursement for the services in dispute is $237.04. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $237.04, 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 $237.04.

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***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 $237.04 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 | November 12, 2014<br>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**.