



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

James L Carlisle

Respondent Name

City of Houston

MFDR Tracking Number

M4-14-1480-01

Carrier's Austin Representative

Box Number 29

MFDR Date Received

January 27, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am requesting that this injured works claim be reviewed for additional monies per rule 133.250."

Amount in Dispute: \$287.47

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the submitted documentation no additional recommendation is being at this time. The bill submitted has been paid in accordance with the fee schedule and correct coding procedures."

Response Submitted by: Injury Management Organization, Inc., 10235 West Little York Road, Suite 265, Houston, TX 77040

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 6, 2013	Physician Services	\$287.47	\$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 medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 197 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
 - 222 – Charge exceeds fee schedule allowance
 - W1 – Workers compensation jurisdictional fee schedule adjustment
 - 601 – Per the fee schedule this service or supply is considered bundled
 - 193 – Original payment decision is being maintained

Issues

1. Did the respondent process the disputed services within Division guidelines?
2. Is additional reimbursement due?

Findings

1. 28 Texas Administrative Code §134.203 (c) states, "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 (date of service annual conversion factor)". The fee calculations are as follows;
 - Procedure code 99203, service date June 6, 2013, 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 1.42 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 1.43278. The practice expense (PE) RVU of 1.62 multiplied by the PE GPCI of 1.002 is 1.62324. The malpractice RVU of 0.14 multiplied by the malpractice GPCI of 0.923 is 0.12922. The sum of 3.18524 is multiplied by the Division conversion factor of \$55.30 for a MAR of \$176.14. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is \$133.00.
 - Procedure code 95886, service date June 6, 2013, 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 0.7 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.7063. The practice expense (PE) RVU of 1.76 multiplied by the PE GPCI of 1.002 is 1.76352. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.923 is 0.02769. The sum of 2.49751 is multiplied by the Division conversion factor of \$55.30 for a MAR of \$138.11.
 - Procedure code 95910, service date June 6, 2013, 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 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 2.018. The practice expense (PE) RVU of 3.29 multiplied by the PE GPCI of 1.002 is 3.29658. The malpractice RVU of 0.12 multiplied by the malpractice GPCI of 0.923 is 0.11076. The sum of 5.42534 is multiplied by the Division conversion factor of \$55.30 for a MAR of \$300.02.
 - Procedure code A4556, service date June 6, 2013, is a bundled code. No separate payment is recommended.
2. The total allowable reimbursement for the services in dispute is \$571.13. This amount less the amount previously paid by the insurance carrier of \$571.14 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 not 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 §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

October 1, 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.