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
Bradley Carpenter MD

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-15-0725-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 23, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This office has attempted to obtain payment for pre-authorized services and continue to get denied on for those pre-authorized services. We are no attempting to obtain assistance from TDI for payment."

Amount in Dispute: $38,792.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received October 31, 2014. However, no position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 23, 2013	L8680	$38,792.96	$14,600.96

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 §134.202 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:
   - 16 – Claim/service lacks information or has submission/billing error(s). Which is needed for adjudication.
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
   - W3 – In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issues

1. What is the applicable rule pertaining to reimbursement?
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 October 31, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. 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." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.
2. Per 28 Texas Administrative Code §134.202 (c) states in pertinent part, "28 Texas Administrative Code §134.203 (d) states, "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;"… Review of Medicare Learning Matters MM8204, "April Quarterly Update for 2013 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule, http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm8204.pdf," finds the allowable for the State of Texas for L8680 is $432.00. Review of the medical claim finds;

    a. Prior authorization from the carrier for "Spinal cord stimulator trial"

    The services in dispute will be calculated as follows; Medicare allowable per unit for the date of service in this dispute is $432.00. The maximum allowable reimbursement is ($432 x 125% = $540.00) x 32 units = $17,280.00.

3. The total recommended payment for the services in dispute is $17,280.00. This amount less the amount previously paid by the insurance carrier of $2,679.04 leaves an amount due to the requestor of $14,600.96. 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 $14,600.96.

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 $14,600.96 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		March , 2015
Signature	Medical Fee Dispute Resolution Officer	Date
		March , 2015
Signature	Medical Fee Dispute Resolution Manager	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.