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
Monarch Pain Care Center

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-15-0759-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 28, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On behalf of myself and Monarch we feel the denials received on this patient's bill for date of service 01/16/2014 is inappropriate."

Amount in Dispute: $600.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed one unit of code 90792. Texas Mutual paid one units of 90792. (Attachment) No additional payment is due."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 16, 2014	90792	$600.00	$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 reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - P12 – Workers compensation jurisdictional fee schedule adjustment
   - 723 – Supplemental reimbursement allowed after a reconsideration of services

Issues

1. What is the applicable rule pertaining to fee guidelines?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Labor 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 (date of service yearly conversion factor)." The maximum allowable reimbursement or MAR will be calculated as follows;
    a. (TDI-DWC Conversion Factor / Medicare Conversion Factor) x Non-Facility Price = MAR
    b. 55.75 / 35.8228 x $145.85 = $226.98
2. The total allowed amount for the services in dispute is $226.98. The Carrier previously paid $232.20. No additional payment 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

		April , 2015
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.