



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

HOUSTON ORTHOPEDIC AND SPINE PHYSICIANS

Respondent Name

STANDARD FIRE INSURANCE CO

MFDR Tracking Number

M4-15-2516-01

Carrier's Austin Representative

Box Number 05

MFDR Date Received

APRIL 13, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Plan EOB dated 1-14-14 denied the claim for Extent of Injury with a notation not finally adjudicated. Prior to the service date the physician office spoke with the adjuster on 10-18-13 and only an evaluation was being approved for the injured body part RT KNEE. The physician office states that the DX CODE 71946 should support the compensable body injury. An appeal was done on 4-10-14 and on 5-2-14 the appeal was denied."

Amount in Dispute: \$453.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider contends they are entitled to reimbursement for the disputed services. The Carrier has review the documentation and determined the Provider has submitted appropriate documentation to substantiate reimbursement. Reimbursement is being issued in accordance with the Division-adopted fee schedule."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: October 24, 2013, Professional Services Work Status Report, \$453.00, \$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 guidelines for reimbursement of professional services.

3. 28 Texas Administrative Code §129.5 sets out the guidelines for reimbursement of the Work Status Report.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - R – Based on Extent of Injury. Not finally adjudicated.

**Issues**

1. Are the insurance carrier’s reasons for denial or reduction of payment supported?
2. Did the insurance carrier reimburse the requestor?
3. Is the requestor entitled to additional reimbursement?

**Findings**

1. The insurance carrier denied disputed services with claim adjustment reason code R – “Based on Extent of Injury.” Upon receipt of the request for medical fee dispute resolution the insurance carrier reviewed the charges billed and opted to reimburse the requestor in accordance with the applicable fee guideline.
2. Review of the payment screen submitted by the insurance carrier finds that the insurance carrier issued payment in the amount of \$311.85; furthermore, in accordance with 28 Texas Administrative Code §134.203 and 28 Texas Administrative Code §129.5 the insurance carrier paid in accordance with the applicable fee guidelines.
3. The requestor has been paid correctly and no further reimbursement is due.

**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**

	Marguerite Foster	August 7, 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, 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 MFDR 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.**