



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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Joshua T Woody

Respondent Name

Indemnity Insurance Co of North

MFDR Tracking Number

M4-16-3546-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

July 28, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We disagree with the amount paid as it appears that this claim was not paid using the 2016 TX Fee Schedule."

Amount in Dispute: \$22.67

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the bill in question was escalated and the review has been finalized. Our bill audit company has determined no further payment is due."

Response Submitted by: Gallagher Bassett, 6404 International Parkway, Suite 2300, Plano, TX 75093

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: March 14, 2016, 27235, \$22.67, \$12.01

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 reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
• P1 – Workers' compensation jurisdiction fee schedule adjustment

Issues

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

Findings

1. 28 Texas Administrative Code §134.203 (c)(1) states in pertinent part,

To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

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). For Surgery when performed in a facility setting, the established conversion factor to be applied is (date of service yearly conversion factor).

The maximum allowable reimbursement is calculated as follows:

$$\text{DWC Conversion Factor} / \text{Medicare Conversion Factor} \times \text{Medicare Fee Schedule or } \$71.32 / \$35.8043 \times \$944.53 = \$1,881.45.$$

2. The maximum allowable for the service in dispute is \$1,881.45. The carrier previously paid \$1,869.44. The remaining balance of \$12.01 is due to the requestor.

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 \$12.01.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$12.01, 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

August , 2016
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.