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
ORTHOTEXAS PHYSICIANS AND SURGEONS

Respondent Name
STARR INDEMNITY & LIABILITY CO

MFDR Tracking Number
M4-19-0301-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
SEPTEMBER 19, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary.

Amount in Dispute: $130.33

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a position summary.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 5, 2018	HCPCS Code L3670-RT	$130.33	$130.32

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, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason code(s):
    - 02777-Service contains a non-covered/modifier.

Issues

1. What is the applicable fee guideline?
2. Is the respondent's denial of payment supported?

3. Is the requestor entitled to reimbursement?

Findings

1. The fee guidelines for professional services are found in 28 Texas Administrative Code §134.203.
2. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   28 Texas Administrative Code §134.203 (b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The disputed code is defined as "L3670- Shoulder orthosis, acromio/clavicular (canvas and webbing type), prefabricated, off-the-shelf." The requestor appended modifier "RT-Right side (used to identify procedures performed on the right side of the body)."

   The respondent denied payment for code L3670 based upon "02777-Service contains a non-covered/modifier." The division finds the respondent's denial based upon "02777" is not supported.

3. To determine the MAR for HCPCS code L3670, the division refers to 28 Texas Administrative Code §134.203(d)(1).

   28 Texas Administrative Code §134.203(d)(1) 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."

   Per the DMEPOS fee schedule HCPCS code L3670 has a fee schedule of $104.26; therefore, $104.26 X 125% = $130.32.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $130.32.

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 $130.32 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	12/7/2018 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.