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
OrthoTexas Physicians

Respondent Name
Arch Indemnity Insurance Co

MFDR Tracking Number
M4-19-3909-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 23, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…this claim rejected for "claim/service lacking information needed for adjudication. See the attached dictation that supports the services rendered."

Amount in Dispute: $180.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier's position remains consistent with its EOB. Carrier maintains that it has paid or will pay all reasonable, necessary and related charges submitted for these dates of service."

Response Submitted by: Flahive, Ogden and Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 18, 2018	L3670	$180.00	$130.33

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:
   - 663 – Reimbursement has been calculated according to state fee schedule guidelines
   - 193 – Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly
   - 201 – (B12) Services not documented in patient's medical records

- P12 – Workers' compensation jurisdictional fee schedule

Issues

1. Is the insurance carrier's reason for denial of payment supported?
2. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking $180.00 for a shoulder orthosis provided on December 18, 2018. The insurance carrier denied disputed services based on the services not documented in the medical record. Review of the submitted information found a document titled, "Patient Product Agreement" signed by the claimant on December 18, 2018 that identifies, "Item # 0814-0194, Shoulder Immobilizer Right."

   Based on this review, the insurance carrier's denial is not supported. The service in dispute will be reviewed per applicable fee guideline.

2. 28 TAC §134.203 (d) (1) states in pertinent part,

   > 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;

   The Texas 2018 DMEPOS fee schedule found an allowable of $104.26 for Code L3670 – Shoulder Othosis.

   The fee calculation = $104.26 x 125 % = $130.33. 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 $130.33.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $130.33, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

______________________	______________________	July 12, 2019
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 Rule §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 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. **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.