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
ROBERT WRIGHT DC

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-04-B929-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
August 20, 2004

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Care performed as a consulting doctor as per 180.22."

Amount in Dispute: $130.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Will allow reimbursement in accordance with Commission medical policies."

Response Submitted by: STATE OFFICE OF RISK MANAGEMENT

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 21, 2003	99204	$130.00	$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 §134.202 sets out the fee guideline for professional medical services provided on or after September 1, 2002.
3. The services in dispute were reduced/denied by the respondent with the following reason code:

   Explanation of benefits
   - L96 – Not treating doctor approved treatment
   - 506 – Re-evaluated bill, payment adjustment
   - F – Fee Guideline MAR Reduction

Issues

1. Did the insurance carrier issue payment for the disputed service rendered on August 21, 2003?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.202 "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications. (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used."

   Per 28 Texas Administrative Code §134.202 "(d) In all cases, reimbursement shall be the least of the: (1) MAR amount as established by this rule; (2) health care provider's usual and customary charge; or, (3) health care provider's workers' compensation negotiated and/or contracted amount that applies to the billed service(s).

   The requestor seeks a total reimbursement in the amount of $130.00 for CPT code 99204 rendered on August 21, 2003. Review of the EOBs dated October 25, 2004 submitted by the insurance carrier supports that payment in the amount of $130.00 was issued to the requestor for disputed dates of service August 21, 2003. As a result, the requestor is not entitled to additional reimbursement for the disputed CPT code.
2. The division finds that the respondent submitted sufficient documentation to support that payment was issued to the requestor for disputed CPT code 99204. As a result, the requestor is not entitled to additional reimbursement for the disputed CPT code 99204.

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

Signature	Medical Fee Dispute Resolution Officer	September 29, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.