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 and Address

ST DAVIDS MEDICAL CENTER
C/O HOLLAWAY & GUMBERT
3701 KIRBY DR STE 1288
HOUSTON TX 77098-3926

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-09-9424-01

MFDR Date Received
June 15, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "it is the position of the Provider that all charges relating to the admission of this claimant are due and payable and not subject to the improper reductions taken by the carrier in this case."

Amount in Dispute: $13,950.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the carrier reimbursed $6,969.90, with additional reimbursements to make a total reimbursement for these dates of service in the amount of $7,362.44. . . . We believe that with the additional reimbursements that we are in compliance with Rule 134.403. "

Response Submitted by: AIU Holdings, Inc., 4100 Alpha Road, Suite 700, Dallas, Texas 75244

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 16, 2008 to June 19, 2008	Outpatient Hospital Services	$13,950.96	$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 §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 181 – PAYMENT ADJUSTED BECAUSE THIS PROCEDURE CODE WAS INVALID ON THE DATE OF SERVICE.
   - 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
   - 45 – Charges exceed your contracted/legislated fee arrangement.
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - 96 – Non-covered charge(s).
   - 59 – Processed based on multiple or concurrent procedure rules.
   - 97 – Payment is included in the allowance for another service/procedure.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 45 – "Charges exceed your contracted/legislated fee arrangement." Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute, nor did the respondent support that the insurance carrier had access to a contractual fee arrangement between the hospital and an informal or voluntary network. The respondent has failed to support this denial reason. The Division concludes that the disputed services are not subject to a contractual fee arrangement. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
2. Review of box 4 of the medical bill for the disputed services finds that the Type of Bill code is 131, which indicates facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, the *Hospital Facility Fee Guideline – Outpatient*. Per §134.403(f), the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables in accordance with subsection (g). Review of the submitted documentation finds no clear indication that the provider requested separate reimbursement of implantables upon submission of the medical bill. Moreover, no documentation was found to support certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable(s) in accordance with the requirements of §134.403(g)(1). The Division concludes that the facility has not requested separate reimbursement of implantables in accordance with subsection (g); therefore, the applicable rule for reimbursement is §134.403(f)(1)(A). Accordingly, the Medicare facility specific reimbursement including outlier payments shall be multiplied by 200 percent.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code J1094 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 80048 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $11.83. 125% of this amount is $14.79

- Procedure code 86900 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 409, which, per OPPS Addendum A, has a payment rate of $7.58. This amount multiplied by 60% yields an unadjusted labor-related amount of $4.55. This amount multiplied by the annual wage index for this facility of 0.9502 yields an adjusted labor-related amount of $4.32. The non-labor related portion is 40% of the APC rate or $3.03. The sum of the labor and non-labor related amounts is $7.35. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $7.35. This amount multiplied by 200% yields a MAR of $14.70.
- Procedure code 86901 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 409, which, per OPPS Addendum A, has a payment rate of $7.58. This amount multiplied by 60% yields an unadjusted labor-related amount of $4.55. This amount multiplied by the annual wage index for this facility of 0.9502 yields an adjusted labor-related amount of $4.32. The non-labor related portion is 40% of the APC rate or $3.03. The sum of the labor and non-labor related amounts is $7.35. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $7.35. This amount multiplied by 200% yields a MAR of $14.70.
- Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $10.86. 125% of this amount is $13.57
- Procedure code 85027, date of service June 17, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $9.04. 125% of this amount is $11.30
- Procedure code 85027, date of service June 18, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $9.04. 125% of this amount is $11.30
- Procedure code 81001 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $4.43. 125% of this amount is $5.54
- Procedure code 71020 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 260, which, per OPPS Addendum A, has a payment rate of $44.29. This amount multiplied by 60% yields an unadjusted labor-related amount of $26.57. This amount multiplied by the annual wage index for this facility of 0.9502 yields an adjusted labor-related amount of $25.25. The non-labor related portion is 40% of the APC rate or $17.72. The sum of the labor and non-labor related amounts is $42.97. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $42.97. This amount multiplied by 200% yields a MAR of $85.94.
- Procedure code 27535 has a status indicator of C, which denotes inpatient procedures not paid under OPPS. Per Medicare payment policies, this procedure is not reimbursable when performed on an outpatient basis. Reimbursement for this procedure is only payable if this procedure is performed in an inpatient setting. The requestor did not meet the requirements as set forth in 28 Texas Administrative Code §§ 134.403(i) and (j) for performing this procedure in an alternative facility setting; therefore, reimbursement is not recommended.

- Procedure code 27899 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 43, which, per OPPS Addendum A, has a payment rate of $112.62. This amount multiplied by 60% yields an unadjusted labor-related amount of $67.57. This amount multiplied by the annual wage index for this facility of 0.9502 yields an adjusted labor-related amount of $64.21. The non-labor related portion is 40% of the APC rate or $45.05. The sum of the labor and non-labor related amounts is $109.26. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $109.26 divided by the sum of all S and T APC payments of $256.74 gives an APC payment ratio for this line of 0.425567, multiplied by the sum of all S and T line charges of $955.00, yields a new charge amount of $406.42 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $109.26. This amount multiplied by 200% yields a MAR of $218.52.
- Procedure code 97530, date of service June 17, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). The fee listed for this code in the Medicare Physician Fee Schedule is $28.77. This amount divided by the Medicare conversion factor of 38.087 and multiplied by the Division conversion factor of 52.83 yields a MAR of $39.91
- Procedure code 97116, date of service June 18, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). The fee listed for this code in the Medicare Physician Fee Schedule is $23.76. This amount divided by the Medicare conversion factor of 38.087 and multiplied by the Division conversion factor of 52.83 yields a MAR of $32.96
- Procedure code 97116, date of service June 19, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). The fee listed for this code in the Medicare Physician Fee Schedule is $23.76. This amount divided by the Medicare conversion factor of 38.087 and multiplied by the Division conversion factor of 52.83 yields a MAR of $32.96
- Procedure code 97001, date of service June 17, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). The fee listed for this code in the Medicare Physician Fee Schedule is $69.31. This amount divided by the Medicare conversion factor of 38.087 and multiplied by the Division conversion factor of 52.83 yields a MAR of $96.14
- Procedure code 97530, date of service June 18, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). The fee listed for this code in the Medicare Physician Fee Schedule is $28.77. This amount multiplied by 3 units is $86.31. This amount divided by the Medicare conversion factor of 38.087 and multiplied by the Division conversion factor of 52.83 yields a MAR of $119.72

- Procedure code 97530, date of service June 17, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). The fee listed for this code in the Medicare Physician Fee Schedule is $28.77. This amount divided by the Medicare conversion factor of 38.087 and multiplied by the Division conversion factor of 52.83 yields a MAR of $39.91
- Per Medicare policy, procedure code 97535, date of service June 17, 2008, may not be reported with procedure code 97530 billed on the same claim. Payment for this service is included in the payment for the primary procedure. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. Although the provider billed the service with an allowable modifier, review of the submitted documentation finds that the modifier is not supported. Separate payment is not recommended.
- Procedure code 97003, date of service June 17, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). The fee listed for this code in the Medicare Physician Fee Schedule is $74.32. This amount divided by the Medicare conversion factor of 38.087 and multiplied by the Division conversion factor of 52.83 yields a MAR of $103.09
- Procedure code 99283 has a status indicator of V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 614, which, per OPPS Addendum A, has a payment rate of $132.17. This amount multiplied by 60% yields an unadjusted labor-related amount of $79.30. This amount multiplied by the annual wage index for this facility of 0.9502 yields an adjusted labor-related amount of $75.35. The non-labor related portion is 40% of the APC rate or $52.87. The sum of the labor and non-labor related amounts is $128.22. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.236. This ratio multiplied by the billed charge of $493.00 yields a cost of $116.35. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $128.22 divided by the sum of all APC payments is 28.90%. The sum of all packaged costs is $5,586.95. The allocated portion of packaged costs is $1,614.77. This amount added to the service cost yields a total cost of $1,731.12. The cost of these services exceeds the annual fixed-dollar threshold of $1,575. The amount by which the cost exceeds 1.75 times the OPPS payment is $1,506.73. 50% of this amount is $753.37. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is $881.59. This amount multiplied by 200% yields a MAR of $1,763.17.
- Procedure code 90774 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 438, which, per OPPS Addendum A, has a payment rate of $51.22. This amount multiplied by 60% yields an unadjusted labor-related amount of $30.73. This amount multiplied by the annual wage index for this facility of 0.9502 yields an adjusted labor-related amount of $29.20. The non-labor related portion is 40% of the APC rate or $20.49. The sum of the labor and non-labor related amounts is $49.69. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $49.69 divided by the sum of all S and T APC payments of $256.74 gives an APC payment ratio for this line of 0.193542, multiplied by the sum of all S and T line charges of $955.00, yields a new charge amount of $184.83 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $49.69. This amount multiplied by 200% yields a MAR of $99.38.

- Procedure code 90775 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 438, which, per OPPS Addendum A, has a payment rate of $51.22. This amount multiplied by 60% yields an unadjusted labor-related amount of $30.73. This amount multiplied by the annual wage index for this facility of 0.9502 yields an adjusted labor-related amount of $29.20. The non-labor related portion is 40% of the APC rate or $20.49. The sum of the labor and non-labor related amounts is $49.69. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $49.69 divided by the sum of all S and T APC payments of $256.74 gives an APC payment ratio for this line of 0.193542, multiplied by the sum of all S and T line charges of $955.00, yields a new charge amount of $184.83 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $49.69. This amount multiplied by 200% yields a MAR of $99.38.
- Procedure code J2405 has a status indicator of K, which denotes nonpass-through drugs and biologicals paid under OPPS with separate APC payment. These services are classified under APC 768, which, per OPPS Addendum A, has a payment rate of $0.26. This amount multiplied by 60% yields an unadjusted labor-related amount of $0.16. This amount multiplied by the annual wage index for this facility of 0.9502 yields an adjusted labor-related amount of $0.15. The non-labor related portion is 40% of the APC rate or $0.10. The sum of the labor and non-labor related amounts is $0.25 multiplied by 4 units is $1.00. Per 42 Code of Federal Regulations §419.43(f) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, drugs, biologicals, and items and services paid at charges adjusted to cost are not eligible for outlier payments. The total Medicare facility specific reimbursement amount for this line is $1.00. This amount multiplied by 200% yields a MAR of $2.00.
- Procedure code 93005 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 99, which, per OPPS Addendum A, has a payment rate of $24.79. This amount multiplied by 60% yields an unadjusted labor-related amount of $14.87. This amount multiplied by the annual wage index for this facility of 0.9502 yields an adjusted labor-related amount of $14.13. The non-labor related portion is 40% of the APC rate or $9.92. The sum of the labor and non-labor related amounts is $24.05. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $48.10 divided by the sum of all S and T APC payments of $256.74 gives an APC payment ratio for this line of 0.187349, multiplied by the sum of all S and T line charges of $955.00, yields a new charge amount of $178.92 for the purpose of outlier calculation multiplied by 2 units is $48.10. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $48.10. This amount multiplied by 200% yields a MAR of $96.20.
- Procedure code G0378 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

4. The total allowable reimbursement for the services in dispute is $2,915.18. This amount less the amount previously paid by the insurance carrier of $7,362.24 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

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	[redacted] Medical Fee Dispute Resolution Officer	January 16, 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.