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
Southwest Center Medical

Respondent Name
City of Dallas

MFDR Tracking Number
M4-09-B522-02

Carrier's Austin Representative
Box Number 53

MFDR Date Received
August 17, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The physical therapy services performed on 2/3 and 2/4/09 were within the first two weeks after the patient's injury. These services were within the ODG treatment guidelines and did not require preauthorization. Provider feels carrier's denial is incorrect and request medical dispute resolution."

Amount in Dispute: $494.59

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment was originally recommended in the amount of $221.55 for the service render on February 3, 2009 and $298.64 for the services rendered on February 4, 2009. Both of these services were paid on March 27, 2009."

Response Submitted by: Harris & Harris, 5900 Southwest Parkway, Building 2, Austin, TX 78735

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 2 – 4, 2009	97530, 97530, A4556	$494.59	$0.95

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 sets out the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - W10 – No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable.

Issues

1. Did the requestor support additional payment is due?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Labor Code §134.203(c), (d) (1) states in pertinent part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) 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 and (d) 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;" Review of the submitted documentation finds the disputed services Maximum Allowable Reimbursement should be calculated as follows;

Submitted Code	Date of Service	Units	Billed Amount	MAR (TDI-DWC Conversion Factor / Medicare Conversion Factor) x Non-Facility Price	Carrier Paid	Amount due
97530	2/03/09	5	$345.00	(53.68 / 36.0666) x $29.77 = $44.31 x 5 = $221.55	$221.55	$0.00
97530	2/04/09	6	$414.00	(53.68 / 36.0666) x $29.77 = $44.31 x 6 = $265.85	$265.66	$0.19
A4556	A4556	1	$48.00	DMEPOS fee schedule x 125% or $12.75 x 125% = $15.94	$15.18	$0.76
				$503.34	$502.39	$0.95

2. The total allowable is $503.34. The amount paid by carrier for the services in dispute is $502.39. The remaining balance is $0.95. 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 $0.95.

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 $0.95, 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	November , 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.