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
Nueva Vida Behavioral Health Associates

Respondent Name
VIA Metropolitan Transit

MFDR Tracking Number
M4-12-2680-01

Carrier's Austin Representative
Box Number 16

MFDR Date Received
April 19, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier has accepted the low back as the compensable injury and is directed to pay all claims related to the compensable injury."

Amount in Dispute: $660.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The DOS in question of 05/09/2011 does not fall within the dates listed on the order, therefore the services were denied and no allowance is due for the DOS billed."

Response Submitted by: Argus Services Corporation, 811 South Central Expressway, Suite 440, Richardson, TX 75080-7429

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 9, 2011	90801	$660.00	$241.64

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 §133.240 sets out the procedures for medical payments and denials.
3. 28 Texas Administrative Code §134.203 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:
   - 193 – Original payment decision is being maintained
   - 151C – Payment adjusted because the payer deems the information submitted does not support this many/frequency of services. "Per Medicare only one unit is allowed with this service."

Issues

1. Did the respondent provide explanation of benefits in compliance with Division rules?
2. What is the applicable rule for reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §133.240(e), (e)(1), (2)(C), and (g): The insurance carrier shall send the explanation of benefits in the form and manner prescribed by the Division .... The explanation of benefits shall be sent to: (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill; and (2) the injured employee when payment is denied because the health care was: …(C)unrelated to the compensable injury, in accordance with § 124.2 of this title ,... (g) An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code § 409.021, and § 124.2 and 124.3 of this title ... if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that:.. (3) the condition for which the health care was provided was not related to the compensable injury." The explanation of benefits has no remark codes related to compensable injury. Therefore the Division finds the carrier did not comply with requirements of Rule 133.240 as only EOB submitted with the dispute show remark codes (193) and (151C). The disputed charges will be reviewed per applicable rules and fee guidelines.
2. Per 28 Texas Administrative Code §133.240(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section and (c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies…"
    - Procedure code 90801, service date May 9, 2011, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 2.8 multiplied by the geographic practice cost index (GPCI) for work of 1 is 2.8. The practice expense (PE) RVU of 1.62 multiplied by the PE GPCI of 0.943 is 1.52766. The malpractice RVU of 0.11 multiplied by the malpractice GPCI of 0.9355 is 0.102905. The sum of 4.430565 is multiplied by the Division conversion factor of $54.54 for a MAR of $241.64.
    - The units billed on the medical claim was three however, the Medically Unlikely Edits in affect for this code only allows payment of one unit.
3. The total allowable reimbursement for the services in dispute is $241.64. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $241.64. 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 $241.64.

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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 $241.64 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.