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
Fondren Orthopedic Group

Respondent Name
Indemnity Insurance Co of North

MFDR Tracking Number
M4-13-3112-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
July 25, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claim was processed and paid incorrectly; CPT codes 29826, 29827 and 29828 were all reimbursed at a non-facility rate and should have been reimbursed at the facility rate."

Amount in Dispute: $702.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of the notice of medical fee dispute was received August 2, 2013. However, no position statement was submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 8, 2012	29827, 29826. 29828	$702.96	$702.96

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 reimbursement guidelines for professional medical services provided in the Texas workers' compensation system.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – This charge was reimbursed in concordance to the Texas medical fee guidelines
   - 29 – Billed date exceeds 95 days from date of service
   - 18 – This line was previously processed and is a duplicate

Issues

1. Did the insurance carrier process payment within Division guideline?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(c) states in pertinent part, (c) 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 a facility setting, the established Division of Workman's Compensation conversion factor to be applied is $68.88(conversion factor 2012). The Medicare conversion factor is $34.0376 per the Physician's fee schedule, (www.cms.gov). The disputed services will be reviewed as below.

Date of Service	Code	Billed	Maximum Allowable Reimbursement MAR	Paid	Amount due
August 8, 2012	29827	$3,000.00	(66.88 / 34.0376) x 1,077.61 = $2,180.70	$1,736.83	443.87
August 8, 2012	29826	$3,000.00	(66.88 / 34.0376) x $177.84 = $359.88	$286.63	73.25
August 8, 2012	29828	$2,000.00	(66.88 / 34.0376) x $921.46 = $1,864.71	$727.17	1,137.54
	Total	$8,000.00	$4,405.29	$2,750.63	$1,654.66

2. The MAR for the disputed services is $4,405.29. The carrier paid $2,750.63. The requestor is seeking $702.96, 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 $702.96.

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 $702.96 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

	Peggy Miller	June 16, 2014
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 28 Texas Administrative Code §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 MDR decision shall deliver a copy of the request 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 §141.1(d).

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