



# 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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Azalea Orthopedics

**Respondent Name**

Retailers Casualty Insurance

**MFDR Tracking Number**

M4-17-2473-01

**Carrier's Austin Representative**

Box Number 17

**MFDR Date Received**

April 14, 2017

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Reasoning for why the disputed fees should be paid: Occupational therapy evaluation was improperly denied for missing G codes, which were present, both in the medical record and on the Form 1500 bill itself."

**Amount in Dispute:** \$175.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Requestor's Table of Disputed Services indicates they want to be reimbursed the full billed amount for CPT code 97003. However, the amount billed does not represent the Medicare guideline amount. Requestor was reimbursed \$130.11 pursuant to the Medicare fee guidelines for CPT code 97003. Therefore, no additional monies are owed for the billed code."

**Response Submitted by:** Downs • Stanford

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 20, 2016	97003	\$175.00	\$0.00

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical

services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 246 – This non-payable code is for required reporting only PT OT or SP codes present without required on-payable codes
  - 18 – Exact duplicate claim/service duplicate claim
  - 95 – Plan procedures not followed. The billed services exceeds the UR amount authorized

**Issues**

1. Are the insurance carrier’s reasons for denial or reduction of payment supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

**Findings**

1. The requestor is seeking reimbursement of \$175.00 for code 97003 – “Occupational therapy evaluation” for dates of service December 20, 2016.

The insurance carrier denied disputed services with claim adjustment reason code 95 – “Plan procedures not followed. The billed services the UR amount authorized.”

The respondent states, “Requestor was reimbursed \$130.11 pursuant to the Medicare fee guidelines for CPT code 97003.” The explanation of benefits dated April 28, 2107 supports this statement. The applicable fee guideline will be reviewed below.

2. 28 Texas Administrative Code §134.203 (c) 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.

Submitted Code	Allowable	DWC Conversion Factor / Medicare Conversion Factor x Allowable = TX FEE MAR
97003	\$81.99	$(56.82/35.8043) \times \$81.99 = \$130.11$

3. The maximum allowable reimbursement for the services in dispute is \$130.11. The carrier paid \$130.11. No additional reimbursement is 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 additional reimbursement for the services in dispute

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
May 19, 2017  
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, 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 MFDR 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.**