



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

Barry W Raborn

Respondent Name

Service Lloyds Insurance Co

MFDR Tracking Number

M4-11-1979-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

February 18, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claim was processed and denied stating physician not payable."

Amount in Dispute: \$85.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received however, no position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 19, 2010	L3310	\$85.00	\$85.00

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.240 sets out the division rules for medical payments and denials.
- 28 Texas Administrative Code §134.202 sets out medical fee guidelines for professional services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - Physician no subject to reim., not license provider

Issues

- Did the carrier process the claim per division rules?
- Is the requestor entitled to reimbursement?

Findings

- 28 Texas Administrative Code §133.240(a) states in pertinent part, "An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with

§133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.” Review of the submitted documents finds the carrier returned the claim to the provider rather than pay or deny payment within 45 days as required by the Division rules. Therefore, the disputed service will be reviewed per applicable rules and guidelines.

2. 28 Texas Administrative Code §134.202(2)(A) states in pertinent part, “To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (2) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule...” The Medicare Pricing, Data Analysis and Coding (PDAC) found at (www.dmepdac.com) shows the allowable for HCPCS code L3310, for date of service 5/19/2010 to be \$74.08. This amount multiplied by 125% or (74.08 x 125% = \$92.60).
3. The Maximum Total Allowable (MAR) is \$92.60. The carrier previously paid \$0.00. The requestor is seeking \$85.00. 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 \$85.00.

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 \$85.00 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	June , 2014 Date
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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.