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 and Address

INTEGRA SPECIALTY GROUP PA
PO BOX 535966
GRAND PRAIRIE TX 75053

Respondent Name
Liberty Insurance Corp

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-12-0787-01

MFDR Date Received
November 7, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "MDR EXHIBIT 2, Proof carrier received the request for reconsideration, Certified mail w/Return receipt, MDR EXHIBIT 3, Pre-authorization Letter(s) / IRO Decision, MDR EXHIBIT 4, Copy of Request for Reconsideration Explanation of Benefits, MDR EXHIBIT 5, Copy of ORIGINAL Explanation of Benefits, MDR EXHIBIT 6, Copy of medical bill(s) (HCFA'S) as originally submitted to the carrier, MDR EXHIBIT 7, Copy of medical bill(s) (HCFA'S) as originally submitted to the carrier for reconsideration, Stamped "Request for Reconsideration", MDR EXHIBIT 8, Narratives / SOAPs."

Amount in Dispute: $1,488.90

RESPONDENT'S POSITION SUMMARY

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

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 1, 2010 to February 7, 2011	Professional Services	$1,488.90	$1,468.80

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 a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out requirements for medical bill submission by health care providers.
3. 28 Texas Administrative Code §133.200 sets out procedures for insurance carriers upon receipt of medical bills.
4. 28 Texas Administrative Code §134.202 sets out medical fee guideline for professional medical services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
   - Z343 - WORK HARDENING

Issues

1. Did the requestor provide documentation to support claims were submitted per Division rules?
2. Did the carrier process submitted medical bills per Division rules?
3. What is the applicable rule to determine applicable fees?
4. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §133.20(b) states in pertinent part, "…a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. Review of the submitted documentations (CMS – 1500) finds the following;

    a. Date of service 11-1-2010; CPT codes 99213, 97110 GP, 97112 GP, 97140 GP, 97032 GP, and 97035 GP were submitted on 11-12-2010 to Liberty Insurance, P.O. Box 7203, London, KY 40742.

    b. Date of service 11-18-2010; CPT code 90801, were submitted on December 10, 2010 to Liberty Insurance, P.O. Box 7203 London, KY 40742.

    c. Date of service 12-7-2010; CPT codes 97545 WH and 97546 WH, were submitted on January 4, 2011 to Liberty Insurance, P.O. Box 7203, London KY, 40742.

    d. The dates of service referenced above were sent in as a re-consideration on September 19, 2011 as supported by Certified Mail Receipt, 7010 2780 0000 9111 9628.

    e. Date of service 1-20-2011; CPT code 99214, was submitted on February 21, 2011 and accepted by carrier (Liberty Insurance) on February 22, 2011.

    f. Date of service 2-7-2011; CPT codes 99212, 99080 73, was submitted on February 24, 2011 and accepted by carrier (Liberty Insurance) on March 2, 2011.

    The Division finds the health care provider did file the services in dispute within time limits of Rule §133.20 therefore; these services will be reviewed per applicable rules and fee guidelines.

2. 28 Texas Administrative Code §133.200 states. "(a) Upon receipt of medical bills submitted in accordance with §133.10(a)(1) and (2) of this chapter (relating to Required Medical Forms/Formats), an insurance carrier shall evaluate each medical bill for completeness as defined in §133.2 of this chapter (relating to Definitions).

    (1) Insurance carriers shall not return medical bills that are complete, unless the bill is a duplicate bill.

    (2) Within 30 days after the day it receives a medical bill that is not complete as defined in §133.2 of this chapter, an insurance carrier shall:

        (A) complete the bill by adding missing information already known to the insurance carrier, except for the following:

            (i) dates of service;
            (ii) procedure/modifier codes;
            (iii) number of units; and
            (iv) charges; or

        (B) return the bill to the sender, in accordance with subsection (c) of this section.

    (3) The insurance carrier may contact the sender to obtain the information necessary to make the bill complete, including the information specified in paragraph (2)(A)(i) - (iv) of this subsection. If the insurance carrier obtains the missing information and completes the bill, the insurance carrier shall document the name and telephone number of the person who supplied the information.

(b) An insurance carrier shall not return a medical bill except as provided in subsection (a) of this section. When returning a medical bill, the insurance carrier shall include a document identifying the reason(s) for returning the bill. The reason(s) related to the procedure or modifier code(s) shall identify the reason(s) by line item.

(c) The proper return of an incomplete medical bill in accordance with this section fulfills the insurance carrier's obligations with regard to the incomplete bill.

Review of submitted documentation found nothing to support the Carrier fulfilled the requirements of Rule §133.200. Therefore, these disputed services will be reviewed per applicable rules and fee guidelines.

3. 28 Texas Administrative Code §134.203(c) is the appropriate division fee schedule for calculation of the maximum allowable reimbursement for the services in dispute. For services in 2010 and 2011, the maximum allowable reimbursement = (TDI-DWC Conversion Factor / Medical CONV FACT) x Non-Facility Price. 28 Texas Administrative Code §134.202(5)(C)(i) is the applicable division fee guideline for calculation of division allowable for Work Hardening/Comprehensive Occupational Rehabilitation Programs. The Work Hardening Maximum Allowable Reimbursement $64.00 x 80% as requestor is not CARF accredited or;

Code	Date of Service	MAR Calculation	Units	Allowable	Carrier Paid
99213	November 1, 2010	(54.32 / 36.8729) x 67.29	1	$99.13	$0.00
97110	November 1, 2010	(54.32 / 36.8729) x 29.33	4	$172.83	$0.00
97112	November 1, 2010	(54.32 / 36.8729) x 30.44	1	$44.84	$0.00
97140	November 1, 2010	(54.32 / 36.8729) x 27.48	1	$40.48	$0.00
97032	November 1, 2010	(54.32 / 36.8729) x 17.09	2	$50.35	$0.00
97035	November 1, 2010	(54.32 / 36.8729) x 12.28	1	$18.09	$0.00
90801	November 18, 2010	(54.32 / 36.8729) x 158.38	1	$233.32	$0.00
97545 WH	December 7, 2010	64.80 x 80%	1	$51.20	$0.00
97546 WH	December 7, 2010	64.80 X 80%	6	$307.20	$0.00
97545 WH	January 4, 2011	64.80 x 80%	1	$51.20	$102.40
97546 WH	January 4, 2011	64.80 x 80%	6	$307.20	$51.20
99214	January 20, 2011	(54.54 / 33.9764) x 102.67	1	$164.81	$0.00
99212	February 7, 2011	(54.54 / 33.9764) x 41.58	1	$66.75	$0.00
99080	February 7, 2011	(Division Fee Schedule) $15.00	1	$15.00	
			Total	$1,622.40	$153.60

4. The requestor has provided documentation to support the disputed services were submitted as clean claims in a timely manner. Also, documentation was provided to support that the services were prior authorized. The total allowable for the disputed services is $1,622.40. The carrier paid $153.60 leaving a balance due to the requestor of $1,468.80. 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 $1,468.80.

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 $1,468.80 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	February 21, 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.