



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

St Mary Behavioral Pain

Respondent Name

Indemnity Insurance Co of North

MFDR Tracking Number

M4-15-0674-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

October 20, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are requesting assistance from you office on the above-mentioned patient for services rendered on 11/15/13."

Amount in Dispute: \$177.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...we have escalated the bills in question for manual review to determine if additional monies are owed."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 15, 2013	90837	\$177.86	\$177.86

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 §134.600 sets out the guidelines for prospective and concurrent review of health care.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 39 – Services denied at the time authorization was requested
 - 16 – Claim/service lacks information or has submission/billing error(s).

Issues

- Was the disputed date of service prior authorized?

2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service as 39 – “Services denied at the time authorization was requested. Per 28 Texas Administrative Code §134.600 (p) states in pertinent part, “Non-emergency health care requiring preauthorization includes:(7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program;” Review of the submitted documentation finds;
 - a. Document dated, October 18, 2013 “Certified Quantity – 6 Doctor, Start date 10/15/13, End date 12/31/13.”

The Carrier’s denial is not supported. The service in dispute will be reviewed per applicable rules and fee guidelines.
2. Per 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.” The maximum allowable reimbursement will be calculated as follows;

$$(TDI-DWC \text{ Conversion Factor} / \text{Medicare Conversion Factor}) \times \text{Non-Facility Price} = \text{MAR or } 55.3 / 34.023 \times 118.67 = \$192.88.$$
3. The maximum allowable reimbursement is \$192.88. The requestor is seeking \$177.86. 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 \$177.86.

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 \$177.86 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	April , 2015 Date
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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.