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
West Texas Rehab Center

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-15-1568-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 27, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "4/24/14 Reprinted all claims and sent to Gallagher Bassett. They were being sent to Medrisk but Medrisk has no account for these claims.
Started to receive payment for claims on 4/28/14 from Medrisk so they did have account on file.
6/21/14 Received fax from Medrisk they are reprocessing dos 3/24-5/23/14.
8/13/14 Reprinted all claims and faxed to Medrisk
8/26/14 Received msg from Medrisk they want documentation for dos 4/9-16/14. Faxed again with claims.
11/19/14 Faxed all claims that I had on Medrisk accounts which was about 6 sets of claim.
No further communication or payment has been received from Medrisk or Gallagher Bassett.

In good faith we treated the patient and should receive payment plus interest on these charges."

Amount in Dispute: $800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This is a medical fee dispute concerning service dates April 9, 2014 to April 16, 2014…

The reimbursements for these services were reduced based upon a contracted amount. Carrier has issued additional reimbursement as follows:

Service date	Payment date	Check #	Amount	
4/7/2014	7/23/2014	325864	$90.00	

Carrier is conducting a further review of the other service dates and will supplement this response with the results of that review."

Supplemental response, dated February 23, 2015: "Carrier has previously responded to this dispute on February 18, 2015. Please see the attached copy of the contract between Med Risk and West Texas Rehab Ctr.

Carrier maintains its position as outlined in the original response."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 9 – 16, 2014	Physical Therapy	$800.00	$0.00

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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of medical bills.
3. 28 Texas Administrative Code §134.203 sets out the fee schedule for billing and reimbursing professional medical services.
4. Texas Labor Code §413.011 defines how fee guidelines may be enacted.
5. Texas Labor Code §413.0115 defines networks within the workers' compensation system.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Day rate limit reached. Charge capped.

Issues

1. Does a network issue exist for the disputed services?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement, claiming the contracted rate has not been paid for the disputed services. The insurance carrier disagrees and states that they have paid according to a contract between Med Risk and the requestor. A review of the networks certified by the Division of Workers' Compensation does not find that Med Risk is a certified network allowed to contract for rates within the workers' compensation system in Texas.

   Texas Labor Code §413.011 (d-4) states, "Notwithstanding this section or any other provision of this title, an insurance carrier, an insurance carrier's authorized agent, or a network certified under Chapter 1305, Insurance Code, arranging for non-network services or out-of-network services under Section 1305.006, Insurance Code, may continue to contract with a health care provider to secure health care for an injured employee for fees that exceed the fees adopted by the division under this section." The statutes in this section that applied to the formation of informal and voluntary networks expired January 1, 2011 with 80(R) HB 473.

   Further, Texas Labor Code §413.0115 (b) states, "Not later than January 1, 2011, each informal network or voluntary network must be certified as a workers' compensation health care network under Chapter 1305, Insurance Code." Because the contract submitted is not certified under Chapter 1305, Insurance Code and the fees involved are below the fee schedule defined by 28 Texas Administrative Code §134.203, the network contract will not be considered.
2. The dispute involves multiple physical therapy codes (97039-GO, 97110-GO, 97140-GO-59, G8985-GO-CJ, and G8984-GO-CL) over multiple dates of service – April 9 – 16, 2014. 28 Texas Administrative Code §133.307 (c)(2) states, in relevant part, "The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division…The request shall include: (M) a copy of all applicable medical records related to the dates of service in dispute." A review of the submitted documentation does not find the medical records to support these charges. Therefore, no additional reimbursement is recommended for these dates of service.

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 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	April 15, 2015
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.