



**/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](http://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**

M4-15-1569-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

January 27, 2015

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "3/4/14- Claim for dos 2/24-27/14 mailed to Gallagher Bassett claim never paid or addressed. Informed that all claims are to go to Medrisk. Remailed to Medrisk 3/14/14.

Claim never addressed after multiple calls.

8/13/14 –reprinted and faxed to Medrisk.

8/26/14 –Medrisk wanted documentation faxed

9/29/-Refaxed to Medrisk

10/29/14-Remailed claims

11/12/14-No payment received on any claims refaxing all claims to Medrisk.

12/2/14- Received letter and claims back from Medrisk asking for documentation.

Printed documentation again mailed certified to Medrisk.

These claims have been mailed/faxed multiple times with no payment received from Medrisk/Gallagher Bassett. Claims were sent in a timely fashion and documentation sent multiple times also. I believe that payment with interest should be made on these charges."

**Amount in Dispute:** \$2410.04

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "This is a medical fee dispute concerning service dates February 24, 2014 to May 29, 2014..."

The reimbursements for these services were reduced based upon a contracted amount. Attached are the EOBs showing the adjustments? Carrier has submitted the billing for additional review and will supplement this response with the results of that re-audit."

Supplemental response, dated February 23, 2015: "Carrier has previously responded to this dispute on 2/18/2015. Please see the attached copy of the contract between Med Risk and West Texas Rehab Center.

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
February 24, 2014 – May 29, 2014	Physical Therapy	\$2410.04	\$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:
  - Negotiated contract rate

### **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 (97022-GO, 97110-GO, 97140-GO, 97140-GO-59, 97004-GO-59, G8985-GO-CJ, G8984-GO-CJ, G8985-GO-CI, and G0283-GO) over multiple dates of service – February 24 – May 29, 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**

\_\_\_\_\_  
Signature

Laurie Garnes  
Medical Fee Dispute Resolution Officer

April 15, 2015  
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.**