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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Gulf Coast Functional Testing

**Respondent Name**
Truck Insurance Exchange

**MFDR Tracking Number**
M4-18-4268-01

**Carrier's Austin Representative**
Box Number 14

**MFDR Date Received**
July 11, 2018

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The carriers denial falls within the time frame of Bulletin #B-0020-17. The division's commissioner issued bulletin #B-0020-17 August 2017. The proclamation states that system participants who reside within the counties listed have the right for the Texas worker's compensation deadlines to be tolled through the duration of the proclamation. The proclamation further states that a waiver is applied to non-emergency healthcare provided out of network."

**Amount in Dispute:** $486.90

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** Submitted documentation does not include a position statement from the requestor. Accordingly, this decision is based on the information available at the time of review.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| December 7, 2017 | 97750 FC | $486.90 | $486.90 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 §134.204 sets out reimbursement guidelines for workers' compensation specific services
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment

codes:

- 243 – Srvs. Not authorized by network/primary care prov
- NNP Out-of-network approval not requested prior to rendering services

**Issues**

1. Was the disputed service within provisions of disaster proclamation?
2. What rule is applicable to reimbursement?

**Findings**

The Austin carrier representative acknowledged receipt of the copy of this medical fee dispute on July 18, 2018. 28 Texas Administrative Code §133.307 states, in relevant part:

> (d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
>
> (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days after the date the respondent received the copy of the requestor's dispute** [emphasis added]. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

The division concludes that respondent failed to respond within the timeframe required by 28 TAC §133.307(d)(1). For that reason, the division will base its decision on the information available.

1. The insurance carrier denied disputed services with claim adjustment reason code NNP – "Out-of-network approval not requested prior to rendering services" for services rendered on December 7, 2017 in Harris County, Texas. The requestor states, "…a waiver is applied to non-emergency healthcare provided out of network."
   The Commissioner's Bulletin B-0020-17 related to Hurricane Harvey states, "For the duration of the Governor's disaster proclamation, and with reference to claims involving workers' compensation claimants residing in a county included in the Governor's disaster proclamation insurance carriers must provide or continue to provide:

   - Processing and delivery of benefit checks and necessary medical care, services, and supplies, including physical therapy, pharmaceutical benefits, and medical equipment,
   - Waiver of penalties and restrictions related to necessary emergency and non-emergency health care provided out-of-network,
   - Coverage of payment for necessary emergency and non-emergency health care services obtained out-of-network,

   As the date of service is within the tolled period and the place of service is in a county within the disaster proclamation, the requestor's position is supported. The carrier's denial is not supported. The services in dispute will be reviewed per applicable fee guidelines.

2. 28 TAC §134.204 (g) states,

   > The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title.

   28 TAC 134.203(c) (1) states,

   > To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

The maximum allowable reimbursement is calculated as (DWC Conversion Factor / Medicare Conversion Factor x Medicare allowable) or 57.5/35.8887 x $33.81 x 9 = $487.53

The allowable for the service in dispute is $487.53. The requestor is seeking $486.90. 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 $486.90.

## *ORDER*

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $486.90, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

**Authorized Signature**

| | | January 17, 2019 |
|---|---|---|
| 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 Rule §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 MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **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**.