



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

ROBERT JOSEPH COOLBAUGH, DC

Respondent Name

LIBERTY INSURANCE CORP

MFDR Tracking Number

M4-21-1683-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

May 24, 2021

Response Submitted by:

Liberty Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

The requestor did not submit a position summary for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

RESPONDENT'S POSITION SUMMARY

"The bill has been reviewed and adjusted for payment -- copies of EOBs, are submitted for your review. Thank you for your consideration in this matter."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 22, 2020	99080	\$310.50	\$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

- 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
- 28 TAC §134.203 sets out the fee guideline for professional medical services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 242 – According to the fee schedule, this charge is not covered
 - U301 – THIS ITEM HAS BEEN REVIEWED ON A PREVIOUSLY SUBMITTED BILL OR IS CURRENTLY IN PROCESS. NOTIFICATION OF DECISION HAS BEEN PREVIOUSLY PROVIDED OR WILL BE ISSUED UPON COMPLETION OF OUR REVIEW
 - 876 – Fee schedule amount is equal to the charge
 - W3 – Additional payment made on appeal/reconsideration

Issues

- Did the insurance carrier issue payment for the disputed services rendered on October 22, 2020 ?
- Is the requestor entitled to additional reimbursement?

Findings

- 1. The requestor seeks reimbursement for CPT Code 99080 rendered on October 22, 2020.

Per 28 TAC §134.203 “(c) 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 \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors and shall be effective January 1st of the new calendar year.”

Per 28 TAC §134.203 “(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of 28 TAC §134.1 of this title.”

The requestor seeks a total reimbursement in the amount of \$310.50. Review of the EOBs submitted by the insurance carrier, supports that a payment in the amount of \$310.50 was issued to the requestor for disputed dates of service October 22, 2020. The insurance carrier issued a second check for interest in the amount of \$3.74. As a result, the requestor is not entitled to additional reimbursement for the service in dispute.

- 2. Review of the submitted documentation finds that the requestor is therefore not entitled to additional reimbursement for the disputed CPT code 99080 rendered on October 22, 2020.

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

Medical Fee Dispute Resolution Officer

July 14, 2021
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 TAC §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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.