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
Fondren Orthopedic

Respondent Name
Insurance Co of the State of PA

MFDR Tracking Number
M4-09-2600-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 12, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We therefore request that this bill be processed according to the EOB stating we were to be paid $129.10."

Amount in Dispute: $141.63

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: December 2, 2008, Flahive, Ogden & Latson "…all bills have been paid in accordance with the Texas Labor Code and contractual provisions."

December 10, 2010, Broadspire "…no network contract exists with Kenneth Mathew Warnock on this claim."

Response Submitted by: Flahive Ogden & Latson, Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 7, 2008	99214, 99080	$141.63	$141.63

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 §134.203 sets out the fee guidelines for professional medical services.
3. 28 Texas Administrative Code §133.4 requires written notification to health care providers regarding contractual agreements for informal and voluntary networks.
4. 28 Texas Administrative Code §129.5 sets out medical bill submission requirements and reimbursement amounts for Work Status reports.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - P8F – This contracted provider or hospital has agreed to reduce this charge
   - ZF7 – This bill was reviewed in accordance with a First Health Owned Contract
   - 18 – Duplicate claim/service

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. Were the services paid in accordance to Division rules and fee guidelines?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code ZF7 – "This bill was reviewed in accordance with a First Health Owned Contract." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on November 29, 2010, the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required, nor does the documentation support that the respondent had been granted access to the health care provider's contracted fee arrangement during the time of the disputed services. The notice does not include the name, physical address, and telephone number of any person given access to the network's fee arrangement with the health care provider as required by §133.4(d)(2)(A). The notice does not include the start date and any end date during which the respondent had been given access to the contracted fee arrangement as required by §133.4(d)(2)(B). The notification letter is not dated. No explanation or documentation was found to support the contents of the submitted postmarked envelope, nor is the envelope addressed to the health care provider. No documentation was found to support receipt of the notification by the health care provider. Neither the signature date, the postmark date, nor the receipt date can be established from the submitted documentation to support delivery to the health care provider in accordance with the requirements of §133.4(e) and 28 Texas Administrative Code §§102(p) and (h). Thorough review of the submitted documentation finds no convincing evidence of timely notification in accordance with §133.4(f). The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines. A supplemental response was received December 10, 2010 from Broadspire that state. "An Affidavit of Non-Existence of Business Record certifying that no network contract exists with Kenneth Mathew Warnock on this claim."

2. 28 Texas Administrative Code §134.203(b) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules." The maximum allowable reimbursement (MAR) is calculated as follows, (TDI-DWC Conversion Factor / Medicare Conversion Factor) x Non-Facility Price or (52.83 / 34.023) x 91.28 = 141.737 or $141.74.

3. The division notes that code 99080 was also listed in the table of disputed services. Pursuant to 28 Texas Administrative Code §129.5 reimbursement in the amount of $15.00 is recommended.
4. The total allowable for the service in dispute is $156.74. The carrier previously paid $0.00. The requestor is seeking $141.63. 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 $141.63.

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 $141.63 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	October 27, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

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