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
Richard J Stephenson

Respondent Name
Liberty Insurance Corp

MFDR Tracking Number
M4-09-4202-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
December 15, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The treatment was in accordance with TWCC Spine Treatment Guidelines, Medicare Guidelines, and MedRisk fee agreement. The total unpaid portion is $781.85 for billing from 02-28-08 to 05-16-08. The total billed for this period was $1,405.00. The total due by the carrier is $781.85 according to the Texas Medical Fee Guidelines."

Supplemental statement from, January 12, 2009 – "The billing was sent into the carrier within the 95 day time limit… The carrier is correct that pre-authorization expired on 05/12/08 and DOS 05/14 along with 05/16 were not preauthorized."

Amount in Dispute: $781.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We base our payments on the Texas Fee guidelines and the Texas Department of Insurance Division of Workers' Compensation Acts and Rules. Dr. Stephenson has a contract with MedRisk that requires that billing go directly to them. MedRisk bills Liberty Mutual and we are required to issue payment to MedRisk. MedRisk issues payment to the provider."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 8, 2008 through May 16, 2008	Chiropractic Services	$781.85	$781.85

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 §134.202 sets out the fee guidelines for professional medical services for dates of service on or after January 3, 2003 until March 1, 2008
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services for dates of service on or after March 1, 2008.

4. 28 Texas Administrative Code §133.4 requires written notification to health care providers regarding contractual agreements for informal and voluntary networks.
5. 28 Texas Administrative Code §102.4 sets out general rules regarding communications.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - X158 – Bill must be sent to MedRisk for repricing
   - P303 – This service was reviewed in accordance with your contract
   - X612 - This bill was reviewed in accordance with your fee for service contract with First Health
   - F286 – Date(s) of service exceed (95) day time period for submission per Rule 408.207

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule pertaining to fee guidelines and reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied/reduced the disputed services as F286 – Date(s) of service exceed (95) day time period for submission per Rule 408.207, X158 – "Bill must be sent to MedRisk for repricing" and X612 – "This bill was reviewed in accordance with your fee for service contract with First Health." The carrier (Liberty Mutual) sent a contract listing "MedRisk" and "ABC Chiropractic." The submitted documentation does support a contract between the provider and Liberty Mutual, or between the provider and First Health as stated in the denial explanation of benefits. Review of the submitted documentation finds the provider did submit the claims timely to Liberty Mutual and as the relationship between Liberty Mutual, MedRisk and the provider is not supported by a contract, the carrier's denial is not supported. Therefore, the disputed services will be reviewed per applicable rules and fee guidelines.

2. For dates of service prior to March 1, 2008, per Rule §134.202 (c) "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1)for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%." For dates of service after March 1, 2008, per 28 Texas Administrative Code §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 date of service yearly conversion factor for dates of service " The maximum allowable reimbursement is calculated as follows;

Date of Service	Submitted Code	Billed Charge	Units	Maximum Allowable Reimbursement (MAR) (TDI/DWC Conversion Factor/ Medicare Conversion Factor) x Non-Facility Price = MAR
February 28, 2008	99213	50.00	1	125% x $56.34 = $70.43
February 28, 2008	97032	70.00	2	125% x $14.77 = $18.46 x 2 = $36.92
February 28, 2008	97035	70.00	2	125% x $10.59 = $13.24x 2 = $26.48
February 28, 2008	97124	70.00	2	125% x $20.53 = $25.66 x 2 = $51.32
February 29, 2008	99213	50.00	1	125% x $56.34 = $70.43
February 29, 2008	97032	70.00	2	125% x $14.77 = $18.46 x 2 = $36.92
February 29, 2008	97035	70.00	2	125% x $10.59 = $13.24x 2 = $26.48
February 29, 2008	97124	70.00	2	125% x $20.53 = $25.66 x 2 = $51.32
March 3, 2008	99213	50.00	1	(52.83/38.087) x $56.34 = $78.15
March 3, 2008	97032	70.00	2	(52.83/38.087) x $14.77 = $20.49 x 2 = $40.98
March 3, 2008	97035	70.00	2	(52.83/38.087) x $10.59 = $14.69 x 2 = $29.38
March 3, 2008	97124	70.00	2	(52.83/38.087) x $20.53 = $28.48 x 2 = $56.96
March 10, 2008	99213	50.00	1	(52.83/38.087) x $56.34 = $78.15
March 10, 2008	97032	70.00	2	(52.83/38.087) x $14.77 = $20.49 x 2 = $40.98
March 10, 2008	97035	70.00	2	(52.83/38.087) x $10.59 = $14.69 x 2 = $29.38
March 10, 2008	97124	70.00	2	(52.83/38.087) x $20.53 = $28.48 x 2 = $56.96

May 14, 2008	99213	50.00	1	(52.83/38.087) x $56.34 = $78.15
May 14, 2008	97530	80.00	2	n/a not authorized
May 14, 2008	97124	70.00	1	n/a not authorized
May 16, 2008	97124	35.00	1	n/a not authorized
May 16, 2008	99213	50.00	1	n/a not authorized
May 16, 2008	97530	80.00	2	(52.83/38.087) x $26.89 = 37.30 x 2 = $74.60
	Total	$1,405.00		$933.99

3. The total maximum allowable reimbursement is $933.99. The carrier previously paid $68.60. The remaining balance is $864.49. The requestor is seeking $781.85. 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 $781.85.

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 $781.85 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 28, 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.