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
Jack P Mitchell

Respondent Name
LM Insurance Corp

MFDR Tracking Number
M4-09-4571-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
December 23, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "TDI/DWC Rules."

Amount in Dispute: $366.00

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. We have verified with MedRisk that this provider does have an active contract with them which covers most of these services. We have reprocessed the bill to consider only those lines that MedRisk has indicated they do not contract for."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 9 – 18, 2008	Chiropractic Services	$366.00	$366.00

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 §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 §102.4 sets out general rules regarding communications.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - X158 – Bill must be sent to Medrisk for repricing
   - X547 - This bill was reviewed in accordance with your fee for service contract with First Health
   - X003 The charge for this procedure, material, and/or service is not normally billed

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 the disputed services as X547 – "This bill was reviewed in accordance with your fee for service contract with First Health." The carrier (Liberty Mutual) sent a contract listing "United Health Care" and "Jack Mitchell." The submitted documentation does not support a contact exists between the provider and MedRisk, or First Health as stated in the denial explanation of benefits. Therefore, the disputed services will be reviewed per applicable rules and fee guidelines.
2. 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." 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
April 9, 2008	99214	898.00	1	(52.83 / 38.087) x 84.89 = $117.75
April 9, 2008	99080-73	15.00	1	Special Report / paid per Division guidelines $15.00
April 11, 2008	99371	11.00	1	Phone call / not separately paid
April 16, 2008	97530	35.00	1	(52.83 / 38.087) x 26.89 = $37.30
April 16, 2008	99212	26.00	1	(52.83 / 38.087) x 34.75 = $48.20
April 16, 2008	E0230	15.00	1	Ice cap or collar / non-covered by Medicare guidelines
April 17, 2008	97530	35.00	1	(52.83 / 38.087) x 26.89 = $37.30
April 17, 2008	98941	45.00	1	(52.83 / 38.087) x 31.76 = $44.05
April 18, 2008	97530	35.00	1	(52.83 / 38.087) x 26.89 = $37.30
April 18, 2008	98941	45.00	1	(52.83 / 38.087) x 31.76 = $44.05
April 18, 2008	G0283	15.00	1	(52.83 / 38.087) x 10.50 = $14.56
	Total	$366.00		$395.51

3. The total maximum allowable reimbursement is $395.51. The requestor is seeking $366.00. 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 $366.00.

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 $366.00 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 , 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.