TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Integrative Health and Medical

Respondent Name
Liberty Insurance Corporation

MFDR Tracking Number
M4-12-2081

Carrier's Austin Representative
Box Number 1

MFDR Date Received
February 16, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our service was performed on 02-17-2011 when the claim was processing as "out of network" as per the treating physician that ordered the testing as well as carrier verification."

Amount in Dispute: $2,320.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. 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
February 17, 2011	99203, 95861, 95903, 95904	$2,320.00	$1,674.16

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 §134.203 sets out the reimbursement guidelines for professional services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - X124 – Payment for this charge is not recommended without medical records
   - X397 – Provider is not within the Liberty Health care network

Issues

1. Did Liberty Mutual respond to the medical fee dispute?
2. Is the insurance carrier's reason for denial of payment supported?
3. What rule is applicable to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The Austin carrier representative for Liberty Insurance Corporation, JT Parker & Associates acknowledged receipt of the copy of this medical fee dispute on February 21, 2012. 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.

   Review of the documentation finds that no response has been received to date. The division concludes that that the insurance Carrier failed to respond within the timeframe required by §133.307(d)(1). The division will base its decision on the information available.

2. The insurance carrier denied disputed services as provider not within Liberty Healthcare network.

   Although Liberty Health Care is listed as a certified network on the Division's webpage, the carrier did not provide convincing evidence that the injured employee is enrolled in this network, nor did the carrier provide documentation to support that the requestor is contracted with Liberty Health.

   The Division concludes that the carrier failed to support its reasons for denial of payment. Therefore, the service in dispute will be reviewed per applicable Division fee guideline.

3. 28 Texas Administrative Code §134.203 (c) states in pertinent part,
   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 calculation per the above is as follows;

Date of service	Submitted Code	Units	Medicare Allowable	Maximum allowable reimbursement = DWC Conversion Factor/Medicare Conversion Factor x Medicare Allowable
February 17, 2011	99203	1	$103.75	54.54/33.9764 x $103.75 = $166.54
February 17, 2011	95861	1	$131.43	54.54/33.9764 x $131.43 = $210.98
February 17, 2011	95903	4	$69.69	54.54/33.9764 x $69.69 x 4 = $447.47
February 17, 2011	95904	10	$52.90	54.54/$33.9764 x $52.90 x 10 = $849.17
			Total	$1,674.16

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 $1,674.16.

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 $1,674.16, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		June 6, 2019
Signature	Medical Fee Dispute Resolution Officer	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 MFDR 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 this *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.