



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

Pegasus Emergency Group TRA

Respondent Name

Service Lloyds Insurance Co

MFDR Tracking Number

M4-14-0190-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

September 16, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have only received a timely filing denial. However, we were not given the W/C info by the patient until 01.22.2013"

Amount in Dispute: \$179.73

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The HCP had a reasonable amount of time to identify the proper payor."

Response Submitted by: Corvel, 3520 Executive Center Blvd, Suite 300, Austin, TX 78731

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 1, 2012	99284	\$179.73	\$179.72

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 §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.20 sets out requirements for medical bill submission by health care providers.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 29 – Time Limit for Filing Claim/Bill has Expired

Issues

- Did the requestor submit a complete, clean claim within division guidelines?
- What is applicable division rule(s)?
- Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.20(b) states in pertinent part, "Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." Review of the submitted documentation finds a letter from Service Lloyds Insurance Company, dated October 5, 2012, that states, "THIS IS A WORKER' COMPENSATION CLAIM. PLEASE FORWARD THE FOLLOWING: x Medical records." This was signed by DaLynn Gaspard, Senior Adjuster. Based on this document the carrier did receive the claim within 95 days of Date of Service, 10/01/2012. Therefore, the services in dispute will be reviewed per applicable rules and guidelines.
2. 28 Texas Administrative Code §134.203(c) states, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications."
 - Procedure code 99284, service date October 1, 2012, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 2.56 multiplied by the geographic practice cost index (GPCI) for work of 1 is 2.56. The practice expense (PE) RVU of 0.59 multiplied by the PE GPCI of 0.912 is 0.53808. The malpractice RVU of 0.22 multiplied by the malpractice GPCI of 0.809 is 0.17798. The sum of 3.27606 is multiplied by the Division conversion factor of \$54.86 for a MAR of \$179.72.
3. The total allowable reimbursement for the services in dispute is \$179.72. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$179.72. 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 \$179.72

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 \$179.72 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

April , 2014
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 Texas Administrative Code §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 Texas Administrative Code §141.1(d).

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