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
John F. Garvish

Respondent Name
Service Lloyds Insurance Co

MFDR Tracking Number
M4-14-0513-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
October 11, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…according to our records this claim was mailed originally on 5/17/2013. On 7/19/13 our office call Service Lloyds for claim status at this point we were informed that Service Lloyds never received the patient's claim."

Amount in Dispute: $48.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider has not submitted any, let alone satisfactory, proof that the initial billing was erroneously sent to one of the above entity typed. The Provider should have contacted the Respondent prior to the expiration of the 95-day Rule are noted above and none apply to this situation."

Response Submitted by: White │Espey, P.O. Box 152949, Austin, TX 78715

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 28, 2013	72070	$48.00	$48.00

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 §134.20 sets out requirements for medical bill submission by health care providers.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29 – Time limit for filing claim/bill as expired
   - 193 – Original payment decision maintained

Issues

1. Did the requestor support that claim was submitted within time limit?

2. Was the [issue 2 *** Tip: write the findings first and then come back here and write the questions that correspond to each numbered finding. The last sentence of each finding should answer the question asked in the issue here.]?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.20(b) states, "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. Chart notes from health care provider with the following:
        i. 3-29-2013 – " Rebilled 2/28/13 OFD 2/28/13 to Paper"
        ii. 5-17-2013 – "Sent HIC to Service Lloyds copy this corresp"

   The Division finds the above to be credible in proving the claim was submitted timely. Therefore, the service in dispute will be reviewed per applicable rules and fee guidelines.
2. 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). To calculate the MAR the following formula will be used. (TDI-DWC conversion factor / Medicare conversion fact) x Non-Facility price or; (55.3 / 34.023) x 32.24 = $52.40
3. Review of the submitted documentation finds that total MAR is $52.40. The requestor is seeking $48.00 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 $48.00.

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 $48.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		August , 2014
Signature	Medical Fee Dispute Resolution Officer	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.