



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4812 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Park Plaza Hospital

Respondent Name

Metropolitan Transit Authority

MFDR Tracking Number

M4-14-0611-01

Carrier's Austin Representative Box

Box Number 19

MFDR Date Received

October 21, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim was in fact filed in a timely manner from the date that we received the carrier information."

Amount in Dispute: \$89.32

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Under Sec. 408.027(a), health care providers (HCPs) have 95 days from the date of service to submit a medical bill to the insurance carrier."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 23, 2012	Professional Services	\$89.32	\$61.46

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 health care providers to pursue a medical fee dispute.
- 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
- 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:

Explanation of benefits dated March 4, 2013

- 29 – The time limit for filing has expired.
- Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. What is applicable rule in determining fee guideline?
3. Is reimbursement due?

Findings

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, “a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.” Documentation was found to support that the services in dispute were submitted to the self-insured “Metro, Transit A on 11/1/12”. Therefore, these services will be reviewed per applicable rules and fee 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.”
3. The applicable calculation of the Maximum Allowable Reimbursement is as follows; Workman’s Compensation Conversion Factor / Medicare Conversion Factor x by non-facility allowable or (54.86 / 34.0376 x 38.13 = \$61.46)

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$61.46.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$61.46 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

April 15, 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.