



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

TEXAS HEALTH DBA INJURY 1 OF DALLAS

**Respondent Name**

HARTFORD INSURANCE COMPANY

**MFDR Tracking Number**

M4-14-0615-02

**Carrier's Austin Representative**

Box Number 47

**MFDR Date Received**

October 21, 2013

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The claims were originally mailed on 03/25/13 and faxed on 06/11/13 and refaxed on 08/30/13 per the attached fax confirmations. As of today we have yet to receive payment and/or EOB. The claims were timely filed per box #31 on CMS-1500."

**Amount in Dispute:** \$559.54

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** The insurance carrier did not submit a response to the DWC060 request. A copy of the DWC060 was placed in the insurance carrier representative box on October 28, 2013. The DWC060 was picked by Deborah Derrickson on October 28, 2013. The division will therefore issue a decision based on the documentation contained in the dispute.

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 25, 2013	96101 and 90791	\$559.54	\$559.54

#### 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 §134.203 sets out the fee guidelines for professional medical services.
- 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 §102.4 sets out the rules for non-Commission communications.
- Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
- Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
- Neither the requestor nor the respondent submitted Explanation of Benefits (EOBs) for review. The disputed charges are therefore reviewed pursuant to the rules and guidelines in effect for the dates of service in dispute.

## 8. Dispute M4-14-0615 History

- Dispute M4-14-0615-01 was originally decided on April 15, 2014.
- On April 29, 2014, the Medical Fee Dispute Resolution withdrew the decision and the dispute was re-docketed under M4-11-0615-02.
- M4-14-0615-02 is hereby reviewed.

## Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?
3. Did the requestor bill in conflict with the NCCI edits?
4. Is the requestor entitled to reimbursement?

## 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 95<sup>th</sup> day after the date the services are provided.”

The requestor submitted documentation to support that the disputed services were submitted to the insurance carrier within 95 days from the dates of service. The requestor submitted a copy of a fax confirmation page dated June 11, 2013 and a copy of a second fax dated August 30, 2013 in support that the bills were submitted to the insurance carrier timely.

2. Texas Labor Code §408.027(a) states, in pertinent part, that “Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment.”

28 Texas Administrative Code §102.4(h) states that “Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.”

Review of the submitted information finds documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Therefore, the requestor submitted sufficient documentation to support that the disputed charges are eligible for a Medical Fee Dispute Resolution review. The division will therefore review the disputed charges pursuant to 28 Texas Administrative Code §134.203 (b).

3. Per 28 Texas Administrative Code §134.203 “(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.”

The division completed NCCI edits to identify edit conflicts that may potentially affect reimbursement. The following was identified:

The requestor billed the following CPT codes 96101-59 and 90791 on March 25, 2013. No NCCI edit conflicts were identified, as a result the disputed charges are reviewed pursuant to 28 Texas Administrative Code § 134.203 (c).

4. 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 \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year.”

Per 28 Texas Administrative Code § 134.203 “(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title.”

The requestor seeks reimbursement in the amount of \$349.08 for CPT code 96101, the MAR reimbursement is \$135.13/unit x 3 units = \$405.40. Therefore, per 28 Texas Administrative Code §134.203(h), the requestor is entitled to the sought amount of \$349.08.

The requestor seeks reimbursement in the amount of \$210.46 for CPT code 90791, the MAR reimbursement is \$246.80. Therefore, per 28 Texas Administrative Code §134.203(h), the requestor is entitled to the sought amount of \$210.46.

Review of the submitted documentation finds that the requestor is entitled to a total recommended amount of \$559.54 for disputed CPT codes 96101 and 90791.

**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 \$559.54.

**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 \$559.54 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

\_\_\_\_\_  
Date

May 5, 2014

**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.**