



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

Channelview Medical Center

Respondent Name

ACIG Insurance Co

MFDR Tracking Number

M4-14-2035-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

March 10, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This denial is invalid as the original bill was submitted on 10-9-13 which is well within the 95-day filing limit. Fax confirmation shows the bill was successfully transmitted."

Amount in Dispute: \$180.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written confirmation of medical fee dispute received March 18, 2014 however no position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 10, 2013	99213, 99080	\$180.10	\$133.65

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 §134.2013 sets out the reimbursement guidelines for professional services.
3. 28 Texas Administrative Code §129.5 details reimbursement guidelines for work status reports.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 29 – Time limit for filing claim/bill has expired
 - W3 – Appeal / Reconsideration

Issues

1. Did the requestor meet Division guidelines when the medical bill was submitted?
2. What is the applicable rule for reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier’s Austin representative box, which was acknowledged, received on March 18, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "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. 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." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.
2. The carrier denied the disputed services as 29 – “Time limit for Filing Claim/Bill has expired.” Review of the submitted documentation finds;

- Faxed confirmation dated October 9 from the health care provider to Tri-Star Risk.

As carrier did not provide evidence to support their denial, the Division finds their denial is not supported. The services in dispute will be reviewed per applicable rules and fee guidelines.

28 Texas Administrative Code §134.203(c) states in pertinent part, (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 (date of service yearly conversion factor).

- Procedure code 99213, service date September 10, 2013, 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 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.97873. The practice expense (PE) RVU of 1.1 multiplied by the PE GPCI of 1.002 is 1.1022. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.923 is 0.06461. The sum of 2.14554 is multiplied by the Division conversion factor of \$55.30 for a MAR of \$118.65.
- 28 Texas Administrative Code §129.5(i) states in pertinent part, “Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section... The amount of reimbursement shall be \$15. (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section;” The provider billed the correct code and modifier. A payment of \$15.00 is supported.

3. The total allowable reimbursement for the services in dispute is \$133.65. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$133.65. 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 \$133.65.

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 \$133.65 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

December 23, 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.