



# 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**

Elite Healthcare Fort Worth

**Respondent Name**

Hartford Insurance Company of

**MFDR Tracking Number**

M4-14-2207-01

**Carrier's Austin Representative**

Box Number 47

**MFDR Date Received**

March 20, 2014

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "I'm taking the next step to get the rest of these claims paid and sending all documentation I have to MDR."

**Amount in Dispute:** \$525.56

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The provider failed to get preauthorization after being advised to do so... The provider forfeited any right to reimbursement."

**Response Submitted by:** Flahive, Ogden & Latson, P.O. Office Drawer 201329, Austin, TX 78720

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 9 – October 17, 2013	Physician Services	\$525.56	\$ 525.56

#### 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 §133.2 sets out definition of terms adopted by the Division related to medical billing and processing for health care services.
3. 28 Texas Administrative Code §133.200 sets out guidelines for insurance carriers receipt of medical bills.
4. 28 Texas Administrative Code §133.204 sets out guidelines related to paper explanation of benefits.
5. The services in dispute were **returned** as unprocessable by the respondent with the following reason codes:
  - Sedgwick administers claim benefits for multiple clients. We are unable to process the enclosed document for the reason(s) indicated below
    - Payment is denied. The treatment was not authorized.

**Issues**

1. Did the respondent appropriately reject the medical bill in dispute?
2. Is the additional reimbursement due to the requestor?

**Findings**

1. 28 Texas Labor Code 133.200(a) states in pertinent part, "Upon receipt of medical bills..., an insurance carrier shall evaluate each medical bill for completeness as defined in §133.2 ..." (1) Insurance carriers shall not return medical bills that are complete, unless the bill is a duplicate bill. (b) An insurance carrier shall not return a medical bill except as provided in subsection (a) of this section. Review of the submitted documentation finds that the requestor submitted a complete medical bill in accordance with 28 Texas Labor Code 133.200(a) and corresponding 28 Texas Labor Code §133.2. The carrier's reason for rejection is not supported because it is not part of the definition of a complete medical bill. The Division finds the carrier improperly rejected the medical bill. The Division further concludes that the carrier did not meet the requirements of 28 Texas Labor Code §133.200.

In its response to medical fee dispute resolution, the carrier states, in pertinent part, that "The provider failed to get preauthorization after being advised to do so." According to 28 Texas Administrative Code §133.240(e) (2)(B), the carrier is required to issue an explanation of benefits in the form and manner prescribed by the Division to the health care provider and the injured employee when denying payment due to "(B) the health care was provided by a health care provider other than: (i) the treating doctor selected in accordance with Labor Code §408.022;..." No documentation was found to support that the carrier issued the electronic or paper explanation of benefits that contained all the elements required by §133.240(e). The Division concludes that the carrier did not meet the requirements of 28 Texas Administrative Code §133.240.

2. For the reasons state above, the services in dispute are eligible for payment pursuant to 28 Texas Administrative Code 134.203(c)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 conversion factor). The Maximum Allowable Reimbursement is therefore calculated as follows:

Date of Service	Submitted Code	Units	Amount Billed	MAR	Amount Due
July 9, 2013	99213	1	\$116.39	2013 DWC Conversion Factor / Medicare Conversion Factor x Participating AMOUNT or (55.3 / 34.023) x \$71.61 = \$116.39	\$116.39
July 9, 2013	99080	1	\$15.00	129.5(h)(i) allows \$15.00	\$15.00
August 14, 2013	99213	1	\$116.39	2013 DWC Conversion Factor / Medicare Conversion Factor x Participating AMOUNT or (55.3 / 34.023) x \$71.61 = \$116.39	\$116.39
August 14, 2013	99080	1	\$15.00	129.5(h)(i) allows \$15.00	\$15.00
September 17, 2013	99213	1	\$116.39	2013 DWC Conversion Factor / Medicare Conversion Factor x Participating AMOUNT or (55.3 / 34.023) x \$71.61 = \$116.39	\$116.39
September 17, 2013	99080	1	\$15.00	129.5(h)(i) allows \$15.00	\$15.00
October 17, 2013	99213	1	\$116.39	2013 DWC Conversion Factor / Medicare Conversion Factor x Participating AMOUNT or (55.3 / 34.023) x \$71.61 = \$116.39	\$116.39
October 17, 2013	99080	1	\$15.00	129.5(h)(i) allows \$15.00	\$15.00
		TOTAL	\$525.56		\$525.56

The total MAR for the services in dispute is \$525.56. 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 \$525.56.

**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 \$525/56 reimbursement for the disputed services.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

July , 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.**