



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

East Texas Emergency Physicians

Respondent Name

Liberty Insurance Corporation

MFDR Tracking Number

M4-15-0429-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

September 29, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "... claim was originally faxed on 03/06/2014... claim was faxed within the filing limit..."

Amount in Dispute: \$629.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The charges of March 2, 2014 were denied as not received within the 95 day timely filing requirement. The services are also totally unrelated to the compensable injury of 9/5/2011."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 2, 2014	Evaluation & Management, emergency department (99284)	\$629.00	\$180.90

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 §102.4 sets out the guidelines for non-Division communications.
- 28 Texas Administrative Code §133.20 sets out the procedures for submission of medical bills.
- 28 Texas Administrative Code §134.203 sets out the guidelines for billing and reimbursing professional medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - F286 – Date(s) of service exceed (95) day time period for submission per rule 408.027

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Does an unresolved compensability issue exist for this dispute?
2. Is the insurance carrier's reason for denial supported?
3. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier stated in their position that the disputed services were "totally unrelated to the compensable injury of 9/5/2011." 28 Texas Administrative Code §133.307 (d)(2)(F) states, in relevant part, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review..." A review of the submitted documentation does not support that this denial reason was presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Therefore, this issue will not be considered.
2. The insurance carrier denied disputed services with claim adjustment reason code F286 – "DATE (S) OF SERVICE EXCEED (95) DAY TIME PERIOD FOR SUBMISSION PER RULE 408.027" 28 Texas Administrative Code §133.20 requires 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."

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..." Review of the submitted information finds the great weight of evidence supports that the requestor submitted the medical bill on March 6, 2014, which is within 95 days from the date the services were provided. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

3. 28 Texas Administrative Code §134.203 states:

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 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. The Division conversion factor for 2014 is \$55.75.

For CPT Code 99284 on March 2, 2014, the relative value (RVU) for work of 2.56 multiplied by the geographic practice cost index (GPCI) for work of 1.000 is 2.560000. The practice expense (PE) RVU of 0.53 multiplied by the PE GPCI of 0.920 is 0.487600. The malpractice RVU of 0.24 multiplied by the malpractice GPCI of 0.822 is 0.197280. The sum of 3.244880 is multiplied by the Division conversion factor of \$55.75 for a total MAR of \$180.90.

4. The total MAR for the disputed services is \$180.90. The insurance carrier paid \$0.00. Therefore, a reimbursement of \$180.90 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 \$180.90.

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 \$180.90 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	<u>Laurie Garnes</u>	<u>August 14, 2015</u>
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, 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 MFDR 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.