



# 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**

Sofia Weigel, M.D.

**Respondent Name**

American Home Assurance Company

**MFDR Tracking Number**

M4-16-0585-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

November 4, 2015

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "... bills have continued to be denied."

**Amount in Dispute:** \$2110.89

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Dr. Weigel changed providers to a service that she owns and is charging for skilled nursing services that [the claimant] may need for other serious health issues, but are not needed for the compensable injury.

Some reimbursements were not made as the bills were not submitted on the proper form."

**Response Submitted by:** AIG

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 16 – November 29, 2014	Home Health Aide	\$2110.89	\$1080.00

#### 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 §133.240 sets out the procedures for payment or denial of a medical bill.
- 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - Workers Compensation State Fee Schedule Adjustment.
  - Procedure/Service was partially or fully furnished by another provider.

- The code does not comply with the definition of a physician service and cannot be reimbursed using physician fee schedule (Medicare).
- A reduction was made because a different provider has billed for the exact services on a previous bill.
- The provider or a different provider has billed for the exact service on a previous bill where no allowance was originally recommended.
- Workers' compensation jurisdictional fee schedule adjustment.
- The charge for the procedure exceeds the amount indicated in the fee schedule.
- Previously paid. Payment for this claim/service may have been provided in a previous payment.
- The provider has billed for the exact services on a previous bill.
- A reduction was made because a different provider has billed for the exact services on a previous bill.
- Fee schedule reimbursement is not valid for this service.

### **Issues**

1. Did the requestor waive the right to medical fee dispute resolution for dates of service October 16 – 25, 2014?
2. Does a dispute exist for dates of service November 15, 17, 18, and 19, 2014 and November 14, 2015?
3. Did the insurance carrier raise relatedness to the compensable injury in accordance with applicable rules?
4. Did the insurance carrier raise the issue of bill submission in accordance with applicable rules?
5. What is the MAR for the disputed services?
6. Is the requestor entitled to additional reimbursement?

### **Findings**

1. 28 Texas Administrative Code §133.307(c)(1) states:

Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

(A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

The dispute includes dates of service October 16, 17, 18, 20, 21, 22, 23, 24, and 25, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on November 4, 2015. This date is later than one year after these dates of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file the dispute for these dates of service with the Division's MFDR Section. Consequently, the requestor has waived the right to medical fee dispute resolution for these dates.

2. The Medical Fee Dispute Resolution Request (DWC060) includes a request for reimbursement for the following services:

- November 15, 2014: S9122/G0156 \$120.00
- November 17, 2014: S9122/G0156 \$120.00
- November 18, 2014: G0156 \$120.00
- November 19, 2014: G0156 \$120.00

28 Texas Administrative Code §133.307(c)(2) states, in relevant part:

... The request shall include:

...

(K) a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB

Review of the submitted documentation does not find explanations of benefits for these services. Submitted documentation does not support that the insurance carrier received a request for an EOB for these services. The division finds that no dispute exists for these services.

The DWC060 includes a request for date of service November 14, 2015. The request does not include the treatment or service code(s) in dispute, the amount billed, the amount paid, or the amount in dispute for this date of services. Therefore, the division finds that no dispute exists for this date of service.

3. In their position statement, the insurance carrier stated that the services in dispute are “not needed for the compensable injury.” 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.

Review of the submitted documentation does not find that relatedness to the compensable injury was included in the denial reasons presented to the requestor prior to the date the request for MFDR was filed, in accordance with the procedures outlined in 28 Texas Administrative Code §133.240. Therefore, this issue will not be considered for this dispute.

4. In their position statement, the insurance carrier stated that “some were not made as the bills were not submitted on the proper form.” 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.

Review of the submitted documentation does not find that this issue was included in the denial reasons presented to the requestor prior to the date the request for MFDR was filed, in accordance with the procedures outlined in 28 Texas Administrative Code §133.240. Therefore, this issue will not be considered for this dispute.

5. 28 Texas Administrative Code §133.204(f) states, “To determine the MAR amount for home health services provided through a licensed home health agency, the MAR shall be 125 percent of the published Texas Medicaid fee schedule for home health agencies.” The published Medicaid fee schedule rate for CPT code G0156 is \$46.09.

The MAR for the disputed services is calculated as follows:

Date of Service	CPT Code	28 TAC §134.204(f)	Units	MAR
11/20/2014	G0156	\$57.61	4	\$230.44
11/21/2014	G0156	\$57.61	4	\$230.44
11/22/2014	G0156	\$57.61	4	\$230.44
11/24/2014	G0156	\$57.61	4	\$230.44
11/25/2014	G0156	\$57.61	4	\$230.44
11/26/2014	G0156	\$57.61	4	\$230.44
11/27/2014	G0156	\$57.61	4	\$230.44
11/28/2014	G0156	\$57.61	4	\$230.44
11/29/2014	G0156	\$57.61	4	\$230.44

6. The total MAR for the disputed services is \$2073.96. The insurance carrier paid \$0.00. The requestor is seeking \$1080.00 for the disputed services. This is the recommended amount.

**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 \$1080.00.

**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 \$1080.00 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>January 13, 2016</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.**