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**
Orthotexas Physicians & Surgeons

**Respondent Name**
ZNAT Insurance Co

**MFDR Tracking Number**
M4-16-1073-01

**Carrier's Austin Representative**
Box Number 47

**MFDR Date Received**
December 22, 2015

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Per the clearing house report DOS 2/23/2015 was translated electronically on 5/8/2015 and accepted by the payer on 5/15/2015. All of these dates fall within the 95 day timely filing deadline."

**Amount in Dispute:** $250.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Zenith Insurance Company maintains its position that the bill was submitted 95 days after the date of service and no reimbursement is due."

**Response Submitted by:** The Zenith

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| February 23, 2015 | 99203 | $250.00 | $163.25 |

## *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**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – the time limit for filing has expired

**Issues**

1. Is the carrier's denial/remark code supported?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor due additional reimbursement?

**Findings**

1. The insurance carrier denied the date of service February 3, 2015 for CPT Code 99203 with claim adjustment reason codes: 29 – "The time limit for filing has expired." 28 Texas Administrative Code §133.20(b) 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." Documentation was found to support that the claim was electronically submitted through the "Availity" claim submission system on May 15, 2015. The payer was, "Zenith Insurance Co." The message, "Payer Accepted" was also found on the "Availity Claim History." The Division finds the carrier's denial is not supported.

   Consequently, the service in dispute will be reviewed per applicable rules and fee guidelines.

2. 28 Texas Administrative Code 134.203 (c) states,

   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).

The maximum allowable reimbursement is calculated as follows: (DWC Conversion Factor / Medicare Conversion Factor) x Participating Amount = TX Fee MAR or (56.2/35.7547) x $103.86 = $163.25.

3. The maximum allowable reimbursement for the service in dispute is $163.25. The carrier previously paid $0.00. The remaining balance of $163.25 is due to the requestor.

**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 $163.25.

## *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 $163.25 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

**Authorized Signature**

| | | January , 2016 |
|---|---|---|
| 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, 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 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**.