



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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Houston Medical Group

Respondent Name

New Hampshire Insurance Co

MFDR Tracking Number

M4-16-1160-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

January 4, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We never received a Denial or Approval for the above claims."

Amount in Dispute: \$3,772.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: 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 January 12, 2016. 28 Texas Administrative Code 133.307 (d)(1) states, "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." As no response was received, this dispute will be based on available information.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 10, 2015 through July 8, 2015	90837, 99213 -25	\$3,772.98	\$3,772.98

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 requirements for medical payments and denials.
- Neither party submitted an explanation of benefits related to the services in dispute.

Issues

1. What is the applicable rule pertaining to the final action on a medical bill?
2. What is the applicable rule that pertains to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Rule §133.240 (a) states,

An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.

Insufficient evidence was found to support that the requirements of Rule 133.240 have been met. The services in dispute will be reviewed per applicable rules and fee guidelines.

2. 28 Texas Administrative Rule §133.203(c)(1) 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 will be calculated as follows;

Date of service	Submitted Code	Claim amount	Allowable	MAR (DWC Conversion Factor/Medicare Conversion Factor) x Allowable = TX Fee MAR
February 10, 2015	90837	\$177.86	\$129.19	$(56.2/35.7547) \times \$129.26 = \203.17
February 18, 2015	90837	\$177.86	\$129.19	$(56.2/35.7547) \times \$129.26 = \203.17
February 26, 2015	90837	\$177.86	\$129.19	$(56.2/35.7547) \times \$129.26 = \203.17
March 4, 2015	90837	\$177.86	\$129.19	$(56.2/35.7547) \times \$129.26 = \203.17
March 11, 2015	90837	\$177.86	\$129.19	$(56.2/35.7547) \times \$129.26 = \203.17
March 31, 2015	90837	\$177.86	\$129.19	$(56.2/35.7547) \times \$129.26 = \203.17
April 7, 2015	90837	\$177.86	\$129.19	$(56.2/35.7547) \times \$129.26 = \203.17
April 15, 2015	99213 25	\$165.10	\$74.09	$(56.2/35.7547) \times \$51.78 = \81.39
April 15, 2015	90837	\$177.86	\$129.19	$(56.2/35.7547) \times \$129.26 = \203.17
April 22, 2015	90837	\$177.86	\$129.19	$(56.2/35.7547) \times \$129.26 = \203.17
April 29, 2015	90837	\$177.86	\$129.19	$(56.2/35.7547) \times \$129.26 = \203.17
May 6, 2015	90837	\$177.86	\$129.19	$(56.2/35.7547) \times \$129.26 = \203.17
May 13, 2015	99213 25	\$203.20	\$74.09	$(56.2/35.7547) \times \$51.78 = \81.39
May 13, 2015	90837	\$177.86	\$129.19	$(56.2/35.7547) \times \$129.26 = \203.17
May 20, 2015	90837	\$177.86	\$129.19	$(56.2/35.7547) \times \$129.26 = \203.17
June 3, 2015	90837	\$177.86	\$129.26	$(56.2/35.7547) \times \$129.91 = \204.19

June 10, 2015	90837	\$177.86	\$129.26	$(56.2/35.7547) \times \$129.91 = \204.19
June 25, 2015	90837	\$177.86	\$129.26	$(56.2/35.7547) \times \$129.91 = \204.19
July 2, 2015	90837	\$177.86	\$129.26	$(56.2/35.7547) \times \$129.91 = \204.19
July 8, 2015	90837	\$177.86	\$129.26	$(56.2/35.7547) \times \$129.91 = \204.19
July 8, 2015	99213 25	\$203.20	\$73.72	$(56.2/35.7547) \times \$74.09 = \116.46
	Total	\$3,772.98	\$2,547.67	\$3,941.40

3. The total allowable reimbursement is \$3,941.40. The requestor is seeking \$3,772.98. 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 \$3,772.98.

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 \$3,772.98 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

Date

March , 2016

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.