



# 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**

Houston Medical Group

**Respondent Name**

City of Houston

**MFDR Tracking Number**

M4-16-1260-01

**Carrier's Austin Representative**

Box Number 29

**MFDR Date Received**

January 12, 2016

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Attached to the appropriate medial documentation is proof that these claims were initially submitted on 05/19/2015 within the time filing limit, but nevertheless we have yet to receive payment."

**Amount in Dispute:** \$329.85

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Based on the submitted documentation no additional payment is being made at this time. In regards to 28 Texas Administrative Code §104.4(h), acceptable proof of timely filing was not submitted."

**Response Submitted by:** Injury Management Organization, Inc

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 11 – 12, 2015	99213, 97012, 97010, A4556, G0283	\$329.85	\$163.61

#### 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 the requirements for medical bill submission by 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
  - 18 – Exact duplicate claim/service
  - 193 – Original payment decision is being maintained.

**Issues**

1. Are the insurance carrier’s reasons for denial or reduction of payment supported?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

**Findings**

1. The insurance carrier denied disputed services with claim adjustment reason code 29 – “The time limit for filing has expired.” 28 Texas Administrative Code §133.20(b) states,

Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.

Review of the submitted documentation finds:

- Document from “Office Ally” shows submission of claim to Sedgwick CMS for date of service May 11, 2015 for a claim totaling \$165.10 with a creation date of May 19, 2015
- Document from “Office Ally shows submission of claim to Sedgwick CMS for date of service May 12, 2015 for a claim totaling \$164.75 with a creation date of May 19, 2015
- Review of submitted medical claim shows claim submitted to “Sedgwick CMS”. The date found in box 31 is May 19, 2015

The Division finds the requestor has submitted sufficient evidence to support the timely submission of the dates of service in dispute. Therefore, the insurance carrier’s denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.203(c)(1) states in pertinent part, “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 (MAR) for the services in dispute is as follows:

Date of Service	Submitted Code	Amount billed	MAR (DWC Conversion Factor / Medicare Conversion Factor) x Participating Amount = TX Fee MAR
May 11, 2015	99213	\$165.10	$(56.2/35.7547) \times \$73.72 = \$115.87$
May 12, 2015	97012	\$49.50	$(56.2/35.7547) \times \$16.28 = \$25.89$
May 12, 2015	97010	\$33.75	Bundled service not separately payable
May 12, 2015	A4556	\$39.00	No separate payment per physician fee schedule
May 12, 2015	G0283	\$42.50	$(56.2/35.7547) \times \$14.09 = \$22.15$
		Total	\$163.61

3. The total allowable for the services in dispute is \$163.61. The carrier previously paid “0”. The remaining balance of \$163.61 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 \$163.61.

**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 \$163.61 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

February , 2016  
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.**