



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

Beaumont Family Practice Associates

Respondent Name

State Office of Risk Management

MFDR Tracking Number

M4-16-1303-01

Carrier's Austin Representative

Box Number 45

MFDR Date Received

January 15, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have made several attempts to received payment on the above claim. In speaking with Heather from SORM on 12/10/15 we were advised to mail all correspondence to SORM so that the above claim can be reviewed and processed for payment. Please note the fax conformation dated 7/29/15 this the date of our original billing submission."

Amount in Dispute: \$215.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon notification of this dispute the Office performed a review of the dispute packet received from Beaumont Family Practice Associates. The Office found that the requestor has failed to submit evidence of filing a request for reconsideration with the carrier prior to filing this medical fee dispute and respectfully requests the Division to dismiss this dispute pursuant to Rule §133.307(f)(A)."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: July 23, 2015, 99203, 99080-73, \$215.00, \$179.06

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 requirements for medical bill submission by health care providers.
3. 28 Texas Administrative Code §129.5 sets out the reimbursement guidelines for work status reports.

4. 28 Texas Administrative Code §134.203 sets out reimbursement guidelines for professional medical services.
5. The carrier denied the disputed services with the following rejection/denial codes:
 - 29 – The time limit for filing has expired
 - 937 – Service(s) are denied based on HBY provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service

Issues

1. Is the respondents' position statement supported?
2. Was the claim submitted timely?
3. What is the applicable rule regarding reimbursement?
4. Is the requestor due additional payment?

Findings

1. The respondents states in their position statement, "The Office found that the requestor has failed to submit evidence of filing a request for reconsideration with the carrier prior to filing this medical fee dispute and respectfully requests the Division to dismiss this dispute pursuant to Rule §133.307(f)(A)." 28 Texas Administrative Code 133.207(f)(3)(A) states in pertinent part,

The division will review the completed request and response to determine appropriate MFDR action.

(3) Dismissal. A dismissal is not a final decision by the division. The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of this section. The division may dismiss a request for MFDR if:

(A) the division determines that the medical bills in the dispute have not been submitted to the insurance carrier for an appeal, when required;

Pursuant to the above referenced rule states, "the Division may dismiss a request for MFDR..." In this instance, the Division will not dismiss but rather review the request based on the appropriate rules and fee guidelines.

2. 28 Texas Administrative Code 133.20 states §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 the following:

- Send Result Report dated July 29, 2015 that shows 5 pages were successfully submitted to carrier
- Send Result Report dated October 27, 2015 that shows 6 pages were successfully submitted to the carrier.

Both of these submission dates are within 95 of the date of service. Therefore, the Division finds the carriers' denial is not supported. The services in dispute will be reviewed per applicable fee guidelines.

3. 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 will be calculated as follows:

$$\text{(DCWC Conversion Factor / Medicare Conversion Factor)} \times \text{Participating Amount} = \text{TX Fee MAR or}$$
$$(56.2 / 35.7547) \times \$104.38 = \$164.06$$

28 Texas Administrative Code 129.5(i) states in pertinent part, "Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the

carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be \$15.” Review of the submitted medical bill finds the requestor submitted \$15.00. This amount is recommended.

4. The maximum allowable reimbursement for the service in dispute is \$179.06. The requestor is seeking \$179.06 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 \$179.06.

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 \$179.06 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.