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
Igor Rakovchik DO

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-16-2202-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
March 29, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134. The carrier has not responded or has denied this claim in its entirety following our filing of Request for Reconsideration. Therefore, we are filing for Medical Dispute Resolution at this time per Rule 133.307."

Amount in Dispute: $485.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Review of the previous audit determined that the denial for 29-Time limit for filing has expired was correct."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 5, 2015	99203, 95910, A4556	$485.16	$477.01

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 §133.2 defines a complete bill.
3. 28 Texas Administrative Code §133.200 defines requirements of an insurance carrier receipt of medical bills from health care providers.
4. 28 Texas Administrative Code §133.10 sets out required bill submission procedures for health care providers.

5. 28 Texas Administrative Code §133.20 sets out requirements for medical claim submission.
6. 28 Texas Administrative Code §134.203 sets out rules and fee guidelines for professional medical services.
7. 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. Was a complete medical bill submitted in accordance with 28 Texas Administrative Code §133.10, 133.20 and §133.200?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. 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." A review of the submitted documentation finds convincing evidence that the requestor submitted a medical bill for date of service October 5, 2015 about October 9th 2015. The respondent rejected and returned the medical bill on October 13, 2015 stating, "The Federal Employer Identification Number (FEIN) on this bill is not set-up on the Comptroller's vendors system." According to 28 Texas Administrative Code §133.200, the carrier shall not return medical bills that are complete. A complete medical bill is defined at 28 TAC 133.2(4) states in pertinent part, "Complete medical bill--A medical bill that contains all required fields as set forth in the billing instructions for the appropriate form specified in §133.10 of this chapter…" The carrier denied the claim on an explanation of benefits dated February 3, 2016 as "timely filing". On March 1, 2016 the respondent sent another notice to the requestor of an incomplete bill.

   When compared to the field requirements of 28 Texas Administrative Code §133.10, the Division finds that the medical bill filed on or about October 9th was complete. The carrier's initial rejection of the medical bill is therefore not supported. The carrier's second rejection was after the claim had adjudicated.

   The division concludes that the requestor timely filed a complete medical bill on or about October 9, 2015. The disputed services were filed timely in accordance with 28 Texas Administrative Code §133.20(b) and are therefore eligible for payment pursuant to the applicable medical fee guideline.

2. 28 Texas Administrative Code §134.203 (c) applicable to the service in dispute states that:

   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	Submitted Charge	Units	Allowable	MAR (DWC Conversion Factor / Medicare Conversion Factor) x Allowable = TX Fee MAR
October 5, 2015	95910	$274.38	1	$201.02	56.2/35.9335 x $201.02 = $314.39 Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $274.38
October 5, 2015	99203	$185.78	1	$110.64	56.2/35.9335 x $110.64 = $173.04 Per §134.203(h), reimbursement is the lesser of

					the MAR or the provider's usual and customary charge. The lesser amount is $185.78
October 5, 2015	A4556	$25.00	1	N/A	This code has a status "P" excluded/bundled item
	Total	$485.16			$477.01

3. The total allowable reimbursement for the services in dispute is $477.01. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $477.01. 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 $477.01.

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 in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $477.01 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	June 15, 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.