



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

GRAPEVINE SURGICARE PARTNERS

Respondent Name

CHARTER OAK FIRE INSURANCE CO

MFDR Tracking Number

M4-16-2208-01

Carrier's Austin Representative

Box Number 05

MFDR Date Received

March 28, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are requesting that this claim paid in accordance with the 2015 Texas Workers Compensation Fee Schedule and Guidelines in effect on this claims date of service."

Amount in Dispute: \$4,676.72

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the documentation and determined the Provider has submitted appropriate documentation to substantiate supplemental reimbursement. Supplemental reimbursement is being issued in accordance with the Division-adopted fee schedule."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Table with 4 columns: Date(s) of Service, Disputed Service(s), Amount In Dispute, Amount Due. Rows include April 17, 2015 for services 25609, 25608 and C1713, and Interest, with a TOTAL row at the bottom.

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 health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.130 sets out the procedures for Interest for Late Payment on Medical Bills and Refunds.
3. Texas Labor Code §413.019 sets out procedures for Interest Earned for Delayed Payment, Refund, or Overpayment regarding medical services and fees.
4. Texas Labor Code §401.023 sets out procedures for computation of Interest or Discount Rate.

Issues

1. Did the insurance carrier issue payment for the disputed charges?
2. What is the date the insurance carrier received the medical bill?
3. What is the interest due per 28 Texas Administrative Code §134.130?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor billed the amount of \$19,124.00, rendered on April 17, 2015. The Requestor seeks additional reimbursement in the amount of \$4,250.72. Review of the submitted documentation supports that the insurance carrier issued payments totaling \$4,250.72. The requestor in correspondence to the Division confirmed receipt of payment for the disputed services, however seeks payment for the interest not reimbursed by the insurance carrier.
2. The requestor alleges that interest is due for the service in dispute. Pursuant to 28 Texas Administrative Code §134.130(a) "Insurance carriers shall pay interest on medical bills paid on or after the 60th day after the insurance carrier originally received the complete medical bill, in accordance with §133.240 of this title (relating to Medical Payment and Denials). Review of the submitted documentation (EOBs) establishes that 5/1/2015 is the receipt date of the medical bill. The Division, therefore concludes that the date the carrier originally received the complete medical bill is 5/1/2015. The Division finds that the requestor is entitled to reimbursement for the interest and interest is determined pursuant to 28 Texas Administrative Code §134.130(c) & (d).
3. 28 Texas Administrative Code §134.130(c) states, "The rate of interest to be paid shall be the rate calculated in accordance with Labor Code §401.023 and in effect on the date the payment was made."
28 Texas Administrative Code §134.130 "(d) Interest shall be calculated as follows: (1) multiply the rate of interest by the amount on which interest is due (to determine the annual amount of interest); (2) divide the annual amount of interest by 365 (to determine the daily interest amount); then (3) multiply the daily interest amount by the number of days of interest to which the recipient is entitled under subsection (a) or (b) of this section.
28 Texas Administrative Code §134.130 "(e) The percentage of interest for each quarter may be obtained by accessing the Texas Department of Insurance's website, www.tdi.state.tx.us." The Division finds that the percentage rate for this quarter is 4.14%.
4. The respondent reimbursed the requestor the amount of \$4,250.75 for disputed services. In accordance with 28 Texas Administrative Code §134.130, the amount due for interest is \$139.82. Therefore, an amount of \$139.82 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement for the interest is due. As a result, the amount ordered is \$139.82.

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 disputed interest amount. The Division hereby ORDERS the respondent to remit to the requestor the interest amount of \$139.82 per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	June 3, 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, 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.