



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

Clinics of North Texas

Respondent Name

State Office of Risk Management

MFDR Tracking Number

M4-16-2324-01

Carrier's Austin Representative

Box Number 45

MFDR Date Received

April 7, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We received confirmation from our clearing house that they accepted this claim to mail to the insurance on 10/02/2015."

Amount in Dispute: \$1,502.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor has failed to submit evidence in the form and manner that has been determined by the Division as being acceptable for proof of timely filing."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 23, 2015	72148	\$1,502.00	\$327.81

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 medical bill submission procedures for health care providers.
3. 28 Texas Administrative Code §102.4 establishes rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
5. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical claim.
6. 28 Texas Administrative Code §134.203 sets out reimbursement 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
 - 274 – A payment or denial has already been recommended for this service
 - Previously paid. Payment for this claim/service may have been provided in a previous payment

Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. The insurance carrier denied the disputed services with claim adjustment reason codes: 29 – “The time limit for filing has expired.” 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.”

Review of the submitted documentation finds:

- Document titled, “Bill Status Report” from P2P Link shows status – “Payer Accepted”
- Accounting note from requestor indicates date of claim acceptance to be 10/02/2015

Based on the above, the Division finds the carrier’s denial is not supported. The services in dispute will be reviewed per applicable rules and fee guidelines.

2. 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).

Date of Service	Submitted Code	Submitted Charge	Allowable	(DWC Conversion Factor / Medicare Conversion Factor) x allowable = Maximum Allowable Reimbursement (MAR)
September 23, 2015	72148	\$1,502.00	\$209.60	56.20/35.9335 x \$209.60 = \$327.81

3. The maximum allowable for the services in dispute is \$327.81. The carrier previously paid \$0.00. The remaining balance is \$327.81. 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 \$327.81.

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 \$327.81 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

_____	<u>Peggy Miller</u>	<u>April , 2016</u>
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, effective May 31, 2012, *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.