



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

James D Weiss MD

Respondent Name

State Office of Risk Management

MFDR Tracking Number

M4-16-2376-01

Carrier's Austin Representative

Box Number 45

MFDR Date Received

April 11, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier is still denying the claim even though Proof of First Submission was sent with the Request For Reconsideration showing the carrier received the claim timely."

Amount in Dispute: \$877.77

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "While the initial bills were returned to the provider for the payee identification error the written communication should have included additional information regarding the requirements on the CMS 1500 not reflecting the appropriate billing provider's required information pursuant to the aforementioned rule."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|------------------|----------------------------|-------------------|------------|
| May 1, 2015 | 99204, 95886, 95911, A4556 | \$877.77 | \$869.62 |

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 May 1, 2015 about May 5th 2015. The respondent rejected and returned the medical bill on May 8, 2015 stating, “Being that the Office utilizes the Texas State Comptroller to issue payments to our vendors there is a requirement for all vendors paid with State funds to have a Texas payee identification number. Pursuant to Rule §133.3, the Office made numerous telephonic and written attempts to the billing provider who failed to neither communicate nor submit the requested information to the Office as requested.” 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...” When compared to the field requirements of 28 Texas Administrative Code §133.10, the Division finds that the medical bill filed on or about May 5, 2015 was complete. The carrier’s initial rejection of the medical bill is therefore not supported.

The division concludes that the requestor timely filed a complete medical bill on or about May 5, 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 |
|-----------------|----------------|------------------|-------|-----------|---|
| May 1, 2015 | 95886 | \$271.16 | 2 | \$87.29 | 56.2/35.9335 x \$87.29 x 2 units = \$273.04 Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is \$271.16 |
| May 1, 2015 | 95911 | \$333.91 | 1 | \$224.62 | 56.2/35.9335 x \$224.62 = \$351.30 Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and |

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|-------------|-------|----------|---|----------|--|
| | | | | | customary charge. The lesser amount is \$333.91 |
| May 1, 2015 | 99204 | \$247.70 | 1 | \$159.60 | 56.2/35.9335 x \$159.60 = \$249.61 Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is \$247.70 |
| May 1, 2015 | A4556 | \$25.00 | 1 | \$13.48 | Per §134.203 (d) The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; \$13.48 x 125% = \$16.85 |
| | Total | \$877.77 | | | \$869.62 |

3. The total allowable reimbursement for the services in dispute is \$869.62. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$869.62. 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 \$869.62.

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 \$869.62 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 9, 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.