



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

HCAA Medical Group PA

Respondent Name

Travelers Indemnity Co

MFDR Tracking Number

M4-16-2860-01

Carrier's Austin Representative

Box Number 05

MFDR Date Received

May 18, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I received a EOB on 2/08/16 advising that the bill had already been paid which it had not."

Amount in Dispute: \$107.09

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has no record of receiving this bill electronically as alleged by the Provider, and contends the Provider has not submitted competent evidence of timely submission."

Response Submitted by: The Travelers

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: October 7, 2015, 99213, 99080-73, \$107.09, \$107.09

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 §134.203 sets out reimbursement guidelines for professional medical services.
4. 28 Texas Administrative Code §129.5 sets out reimbursement guidelines for work status reports.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- B13 - Previously paid. Payment for this claim/service may have been provided in a previous payment

- 16 – Claim/service lacks information which is needed for adjudication
- 29 – The time limit for filing has expired

Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. What is the applicable rule that pertains to reimbursement?
3. Is the requestor entitled to additional reimbursement?

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 an explanation of benefits from the insurance carrier for the services in dispute (October 7, 2015) with the date of February 1, 2016 showing claim was received/processed by the carrier. 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)(1) states in pertinent part,

To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

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 for Code 99213 is calculated as follows;

DWC Conversion Factor/Medicare Conversion Factor x Allowable = TX Fee MAR or

$$56.2/35.9335 \times \$70.02 = \$109.51$$

The maximum allowable reimbursement for Code 99080 -73 is detailed in 28 Texas Administrative Code 129.5(i)

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. A doctor shall not bill in excess of \$15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section.

The recommended allowance is \$15.00.

3. The total allowable amount for the services in dispute is \$124.51. The requestor is seeking \$107.09. 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 \$107.09.

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 \$107.09 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature

Peggy Miller

Medical Fee Dispute Resolution Officer

June , 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, 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.