



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

MedSpring

Respondent Name

Texas Mutual

MFDR Tracking Number

M4-16-3051-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

June 6, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In regards to the above claim, appeals were sent twice to the insurance (Texas Mutual WC) stating the claim was filed within the timely filing limit. As per our records the claim was filed to a commercial insurance (Aetna) as we were not aware that this was a work related injury, also the claim was processed b Aetna insurance towards Patient's deductible in a timely manner."

Amount in Dispute: \$672.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "One year from disputed date 3/18/15 is 3/18/16. The TDI/DWC date stamp lists the received date stamp lists the received date as 6/6/16 on the requestor's DWC-60 packet, a date greater than one year from 3/18/15. The requestor has waived its right to DWC MDR."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 18, 2015	99203 -25, 29125, 73130 - RT, Q4022	\$672.00	\$322.63+

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 the reimbursement guidelines for the services in dispute.
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. Are the insurance carrier’s reasons for denial or reduction of payment supported?
2. What is the rule applicable 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.” Texas Labor Code §408.0272(b) provides that:

Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:

- (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:
 - (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;
 - (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or
 - (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title; or
- (2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

Review of the submitted documentation finds the following:

- Explanation of benefits from commercial payer with date 3/31/2015 for the requestor and the date of service/services in dispute.
- Document from respondent dated April 16, 2015 requesting medical records for date of service in dispute which acknowledged receipt of the claim.

Documentation was found to support that an exception described in Texas Labor Code §408.0272 apply to the service in this dispute. For that reason, the health care provider has supported the timely submission of the medical bill not later than 95 days after the date the disputed services were provided. The carrier’s denial is not supported.

2. 28 Texas Administrative Code §134.203 (c) states in pertinent part,

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 services in dispute will be calculated as follows;

Date of Service	Submitted Code	Submitted Amount	Allowable	Units	MAR (DWC Conversion Factor / Medicare Conversion Factor) x Allowable
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March 18, 2015	99203	\$323.00	\$108.80	1	$56.2/35.7547 \times \$108.80 = \171.01
March 18, 2015	29125	\$202.00	\$65.79	1	$56.2/35.7547 \times \$65.79 = \103.41
March 18, 2015	73130	\$102.00	\$30.67	1	$56.2/35.7547 \times \$30.67 = \48.21
				Total	\$322.63

Regarding code Q4022. Review of the Medicare and Texas Medicaid Fee Schedules finds no allowable for this code. 28 Texas Administrative Code §134.203 (f) states,
 For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).

28 Texas Administrative Code §134.1(e) states,
 Medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with:
 (1) the Division's fee guidelines;
 (2) a negotiated contract; or
 (3) in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section

28 Texas Administrative Code §134.1 (f) states,
 Fair and reasonable reimbursement shall:
 (1) be consistent with the criteria of Labor Code §413.011;
 (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
 (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable.”

Review of the submitted documentation finds that:

- The requestor does not discuss or demonstrate how reimbursement of \$45.00 is a fair and reasonable reimbursement.
- The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.

The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1. No additional payment is recommended for disputed code Q4022.

3. The maximum allowable for the services in dispute is \$322.63. The carrier previously paid \$0.00. The remaining balance of \$322.63 is due to the requestor.

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 \$322.63.

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 \$322.63 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 , 2016 Date
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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.