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
Houston Medical Group

Respondent Name
Pennsylvania Manufacturers Indemnity Co

MFDR Tracking Number
M4-17-0036-01

Carrier's Austin Representative
Box Number 48

MFDR Date Received
September 6, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Initially the claim was submitted on 10.5.15. We never received a Denial or Approval for the above claims."

Amount in Dispute: $180.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of an acknowledgement of receipt of the medical fee dispute resolution on September 14, 2016. Texas Administrative Code §133.307 (d) (1) states, "Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division. (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." As no response was received this dispute will be reviewed based on available information.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 15, 2015	99080 -73, 99213	$180.10	$130.88

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 the requirements for claim submission by health care providers.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical

services.

4. 28 Texas Administrative Code §129.5 sets out the reimbursement guidelines for work status reports.
5. The insurance carrier reduced payment for the disputed services with the following adjustment codes:
   - 29 – Billed date exceeds 95 days from date of service

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the rule applicable to reimbursement of professional medical services?
3. What is the rule applicable to work status reports?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The services in dispute are for professional medical services (99213, 99080 -73) for date of service September 15, 2015.

   The insurance carrier denied disputed services with claim adjustment reason code 29 – "billed date exceeds 95 days from date of service." 28 Texas Administrative Code §133.20 (b) states in pertinent part,

   > Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.

   The respondent submitted no position statement in this dispute but rather copies of multiple e-mail communications between parties.

   The requestor states, "Initially the claim was submitted on 10.5.15."

   Review of the submitted documentation finds;

   - Document titled, "FS_HCFA_286638695_IN_C, with Date processed of 10/22/2015
     - Under Payer (PayerID) "GallagherBassettsServicesInc. (TP057)
     - Accepted claim detail: DOS 09/15/2015, CPT 99213, Last/First (claimant), Payer TPO57

   The Division concludes sufficient evidence was presented to support the timely submission of the medical claim within 95 days from the date the services as stated by the requestor.

   The services in dispute will therefore be reviewed per applicable rule and fee guidelines.

2. Professional medical services are subject to provisions of 28 Texas Administrative Code §134.203(c) which 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 submitted code was 99213 – "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family."

   Review of the Physician Fee Schedule at www.cms.gov, finds the allowable to be $74.09.

The applicable fee is calculated as follows: (DWC Conversion Factor/Medicare Conversion Factor) x Physician fee schedule allowable for date of service or (56.2/35.9335) x $74.09 = $115.88.

3. The requestor submitted a claim for 99080 with a 73 modifier. 28 Texas Administrative Code §129.5 (i) states in pertinent part,

   > 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 … The amount of reimbursement shall be $15.

4. The total allowed reimbursement for the services in dispute is ($115.88 + $15.00) for a total of $130.88. 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 $130.88.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 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 $130.88, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		October 21, 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.