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
GABRIEL JASSO, PHD

Respondent Name
SENTINEL INSURANCE COMPANY LTD

MFDR Tracking Number
M4-18-2955-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
April 16, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has reduced this claim inappropriately and not in accordance and compliance with TDI-DWC Rule 133 and 134. The carrier has not responded or denied this claim in its entirety following our filing of Request for Reconsideration."

Amount in Dispute: $970.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Of the gross payment due on the above dispute, $970.30 was made payable to the IRS due to Backup Withholding and $2,495.04 was made payable to the Vendor. . . . the vendor did not provide The Hartford with the requested Form W-9 so Backup Withholding has been imposed."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 27, 2017	Professional Medical Services	$970.30	$970.30

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 §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §133.2 defines words and terms related to medical billing and processing.
4. 28 Texas Administrative Code §133.210 sets out documentation requirements.
5. 28 Texas Administrative Code §133.240 sets out provisions regarding medical payments and denials.
6. Texas Labor Code §408.027 sets out requirements for payment of health care providers.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 1115 - WE FIND THE ORIGINAL REVIEW TO BE ACCURATE AND ARE UNABLE TO RECOMMEND ANY ADDITIONAL ALLOWANCE

Issues

1. Did the insurance carrier pay the medical bill in accordance with the requirements of division rules?
2. What is the recommended payment for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier issued an explanation of benefits (EOB) for the disputed services calculating total payment due of $3,465.34, which was the amount of the total charges on the bill. Consequently, there were no denial codes or payment reduction reasons listed on the initial EOB, as the payment amount determined by the carrier was the same as the amount billed by the provider.

   However, the check issued by the insurance carrier (dated January 5, 2018) was for the amount of $2,495.04 — not the amount of $3,465.34 stated as due on the EOB. Review of the materials submitted to MFDR finds no explanation to accompany the check or on the EOB explaining the reason for the shortage in the check amount. The respondent's position statement asserts that "$970.30 was made payable to the IRS due to Backup Withholding" and that though the provider "was issued a 1st B-Notice on 10/23/2017; the vendor did not provide The Hartford with the requested Form W-9 so Backup Withholding has been imposed."

   The division notes that a completed IRS form W-9 for the health care provider is included in the materials accompanying the provider's MFDR request. The division notes further that this completed IRS form W-9 was also faxed to the insurance carrier as part of the provider's reconsideration request packet, dated as transmitted to The Hartford on February 20, 2018.

   Regardless, Labor Code §408.027(b) requires that the insurance carrier must pay, reduce, deny, or determine to audit the health care provider's claim not later than the 45th day after the date of receipt by the carrier of the provider's claim. Additionally, §408.027(f) requires that any such payment "shall be in accordance with the fee guidelines authorized under" Subtitle A of the Texas Workers' Compensation Act.

   Similarly, Rule §133.240(a) requires that an insurance carrier:

   > shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill.

   Rule §133.2(6) defines "final action on a medical bill" as:

   > (A) sending a payment that makes the total reimbursement for that bill a fair and reasonable reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement); and/or
   >
   > (B) denying a charge on the medical bill.

   Rule §133.210(d) sets out the requirements for an insurance carrier to request additional documentation to process a medical bill.

   Although the insurance carrier response states the provider "was issued a 1st B-Notice on 10/23/2017," the respondent did not submit any documentation to support that a proper request for additional information was sent to the health care provider in accordance with the requirements of Rule §133.210(d).

   Moreover, even had the carrier done so, Rule §133.240(a) further states that "an insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation."

   Review of the submitted information finds the carrier neither denied payment nor made payment in accordance with division fee guidelines as required by Labor Code §408.027(f). Neither did the carrier take final action as required by Rule §133.240(a) in accordance with the definition in Rule §133.2(6).

   The division thus concludes the insurance carrier has failed to make payment on the medical bill in accordance with the requirements of the Labor Code and division fee guidelines.

2. This dispute regards medical services with reimbursement subject to the *Medical Fee Guideline for Professional Services*, 28 Texas Administrative Code §134.203, requiring the maximum allowable reimbursement (MAR) be determined by applying Medicare payment policies with modifications set out in the rule. The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by a conversion factor. The DWC conversion factor is substituted to calculate the MAR. The 2017 DWC conversion factor is $57.50.

   Reimbursement is calculated as follows:

   - Procedure code 96118 has a Work RVU of 1.86 multiplied by the Work GPCI of 1.015 is 1.8879. The practice expense RVU of 0.82 multiplied by the PE GPCI of 1.012 is 0.82984. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.77 is 0.0539. The sum is 2.77164 multiplied by the DWC conversion factor of $57.50 for a MAR of $159.37 at 18 units is $2,868.66. Per Rule §134.203(h), reimbursement is the lesser of the MAR or the provider's charge. The lesser amount is $2,864.70.
   - Procedure code 96116 has a Work RVU of 1.86 multiplied by the Work GPCI of 1.015 is 1.8879. The practice expense RVU of 0.65 multiplied by the PE GPCI of 1.012 is 0.6578. The malpractice RVU of 0.09 multiplied by the malpractice GPCI of 0.77 is 0.0693. The sum is 2.615 multiplied by the DWC conversion factor of $57.50 for a MAR of $150.36 at 4 units is $601.44. Per Rule §134.203(h), reimbursement is the lesser of the MAR or the provider's charge. The lesser amount is $600.64.

3. The total reimbursement for the disputed services is $3,465.34. The insurance carrier paid $2,495.04. The amount remaining due is $970.30. This amount is recommended.

Conclusion

The division would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though not all the evidence was discussed, it was considered.

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 $970.30.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $970.30, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	October 12, 2018
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 Rule §133.307.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.