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
OrthoTexas Physicians

Respondent Name
Merged Royal Insurance Co of America

MFDR Tracking Number
M4-19-0487

Carrier's Austin Representative
Box 11

MFDR Date Received
September 28, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim was submitted to Liberty Mutual because we were not aware that the claims needed to be filed to ArrowPoint Capital."

Amount in Dispute: $128.52

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Bill for $190.99 for 01-05-2018 dos was received on 07-23-2018 (199th day). Bill was denied as time limit for filing had expired."

Response submitted by: Arrowpoint Capital

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 5, 2018	99213, 99080	$128.52	$128.52

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 requirements of medical bill submission.
3. Texas Labor Code 408.0272 sets out the workers compensation timely billing and exceptions guidelines.
4. 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. Is the insurance carrier's reason for denial supported?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking $128.52 for professional medical services rendered on January 5, 2018." The insurance carrier denied disputed services with claim adjustment reason code 29 – "The time limit for filing has expired."

   28 TAC §133.20 (b) states in pertinent part,

   > In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied.

   Texas Labor Code §408.0272. (b) and (c) states in pertinent part,

   > (b) 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:
   > >
   > > > (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title;

   Review of the submitted documentation found an explanation of benefits dated April 24, 2018 from Liberty Mutual Insurance with the notice, "This charge was billed in error." The explanation of benefits from Arrowpoint Capital Corp indicates a date of rcvd, July 23, 2018. This date is less than 95 days from the date the health care provider was notified of the incorrect workers' compensation carrier. The insurance carrier's denial is not supported. The services in dispute will be reviewed per applicable Division fee guidelines.

2. The rule applicable to the office visit is 28 TAC §134.203 and 28 TAC §129.5 for the special report submitted on January 5, 2018.

   28 TAC §134.203 (c) (1) states,

   > (c) 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 physician fee schedule allowed amount is $71.37. 58.31/35.9996 x $71.37 = $115.60.

   28 TAC §129.5 (j) states,

   > Notwithstanding any other provision of this title, a doctor or delegated physician assistant may bill for, and an insurance 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 insurance carrier, its agent, or the employer through its insurance carrier asks for an extra copy. The amount of reimbursement shall be $15.

Review of the submitted medical bill finds the health care provided submitted code 99080 -73 in the amount of $15.00. This amount is recommended.

3. The total allowed amount of the services in dispute is $130.60. The requestor is seeking $128.52. 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 $128.52.

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 $128.52, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

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Authorized Signature

		January 24, 2019
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, 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. **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.