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
Orthotexas Physicians and Surgeons

Respondent Name
Collin County

MFDR Tracking Number
M4-19-2134-01

Carrier's Austin Representative
Box # 29

MFDR Date Received
December 14, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the clearing house report 5/24/18 was transmitted on 6/2/18 to our clearinghouse Availity. This claim was dropped to paper & mailed from Availity to Tristar on 6/4/18. All of these dates are within the 95 day filing deadline."

Amount in Dispute: $354.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the requestor. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 24, 2018	Professional medical services	$354.00	$231.59

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. 28 Texas Administrative Code §129.5 Work Status Reports
4. 28 Texas Administrative Code §134.1 details fair and reasonable reimbursement
5. 28 Texas Administrative Code §134.203 sets out reimbursement for professional medical services
6. 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. Did the insurance carrier respond to the medical fee dispute?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. What rule is applicable to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The Austin carrier representative acknowledged receipt of the copy of this medical fee dispute on January 2, 2019. 28 Texas Administrative Code §133.307 states, in relevant part:

   (d) Responses. 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** [emphasis added]. 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.

   Review of the documentation finds that no response has been received on behalf of the insurance carrier to date. The division concludes that the insurance carrier failed to respond within the timeframe required by §133.307(d)(1). The division will base its decision on the information available.

2. The requestor is seeking $354.00 for professional medical services rendered on May 24, 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,

   (b) 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.

   Review of the submitted documentation found a claim for the services in dispute was submitted on June 4, 2018. Based on this information the requirements of submitting a claim within 95 days from the date of service was met. The fee guideline calculation is shown below.

3. 28 TAC §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.

   (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 Medicare physician fee schedule for 2018 found the following allowable for the services in dispute:

   - Procedure code 99203 – Office/outpatient visit new, $105.39. 58.31/35.9996 x $105.39 = $170.70
   - Procedure code 73030 – x-ray exam of shoulder, $28.33. 58.31/35.9996 x $28.33 = $45.89
   - 28 TAC §129.5 (j) applies to code 99080 – Work status report, and 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.

The allowed amount is $15.00

28 TAC §134.1 (e) (3) and (f) apply to code A9999 – Miscellaneous DME supply or accessory, not otherwise specified and states,

(e) Medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with:

(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.

(f) 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.

Insufficient evidence was found to support an applicable fee guideline or negotiated contract for the amount billed of $15.00. No payment can be recommended as requirements of Rule 134.1 (f) were not met.

4. The total allowed amount for the services eligible for reimbursement is $231.59. 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 $231.59.

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 $231.59, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		February 15, 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.