TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Medical Associates of Brownsville

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-19-2155-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
December 17, 2018

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 26, 2017	99214	$415.00	
March 26, 2018	99214	$420.00	$0.00
July 31, 2018	99214	$420.00	

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 138 – Appeal procedures not followed or time limits not met
   - 150 – Payer deems the information submitted does not support this level of service
   - 16 – Claim/service lacks information submitted does not support this level of service
   - 193 – Original payment decision is being maintained
   - 225 – The submitted documentation does not support this level of service
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

Issue

1. Did the requestor waive the right to medical fee dispute resolution?
2. What rule is applicable to reimbursement?

Findings

1. The insurance carrier states in their position statement, "One year from dispute date 9/26/17 is 9/26/18.

The TDI/DWC date stamp list the received date as 123/17/18 on the requestor's DWC-60 packet a date greater than one year from 9/26/17."

28 Texas Administrative Code §133.307(c)(1) states:

Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request.

(A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

(B) B) A request may be filed later than one year after the date(s) of service if:

(i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability;

(ii) a medical dispute regarding medical necessity has been filed, the medical fee dispute must be filed not later than 60 days after the date the requestor received the final decision on medical necessity, inclusive of all appeals, related to the health care in dispute and for which the insurance carrier previously denied payment based on medical necessity; or

(iii) the dispute relates to a refund notice issued pursuant to a division audit or review, the medical fee dispute must be filed not later than 60 days after the date of the receipt of a refund notice.

The date of the service in dispute is September 26, 2017. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on December 17, 2018. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The insurance carriers' position is supported, no additional payment is recommended.

2. The respondent states, "In order to resolve dates 3/26/18 and 7/31/18 Texas Mutual has elected to pay these two dates." 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 physician fee schedule allowable found at www.cms.gov is $105.49. The maximum allowable reimbursement is calculated at DWC conversion factor/Medicare conversion factor x allowable or 58.31/35.9996 x $105.47 = $170.87. Review of the explanation of benefits from January 9, 2019 finds the insurance carrier paid $170.87 for date of service March 26, 2018 and $170.87 for date of service July 31, 2018. No additional payment is recommended.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		February 13, 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 28 Texas Administrative Code §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 MDR 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.