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
NMP of Greater Texas

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-19-3411-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 11, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: $1,414.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill was late and is still late. No payment is due."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 27, 2018	99284, 93010	$1,414.00	$208.90

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 §133.20 sets out requirements of medical bill submission.
2. 28 Texas Administrative Code §102.4 sets out general guidelines for non-commission communications.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
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 reasons for denial of payment supported?
2. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking $1,414.00 for emergency room services rendered on June 27, 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 finds;

   - 1500 Medical bill with signature date September 12, 2018
   - Fax confirmation sheet showing receipt of documents September 13, 2018

   28 TAC §102.4 (h) states,

   > Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:
   >
   > (1) the date received, if sent by fax, personal delivery or electronic transmission or,

   Based on the above, the insurance carrier's denial is not supported the services in dispute will be reviewed per applicable fee guideline.

2. The professional medical services are reimbursed subject to TAC 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 Medicare 2018 Physician fee schedule allowable for code 99284 is $120.24. The 2018 DWC Conversion factor is 58.31. The 2018 Medicare Conversion Factor is $35.9996. 58.31/35.9996 x $120.24 = $194.76.

   The Medicare 2018 Physician fee schedule allowable for code 93010 is $8.73. 58.31/35.9996 x $8.73 = $14.14.

   The total allowable for the services in dispute is $208.90. 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 $208.90.

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 $208.90, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 5, 2019 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.