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
MEDICAL ASSOCIATES OF BROWNSVILLE

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-4414

Carrier's Austin Representative
Box Number 54

MFDR Date Received
June 7, 2019

Response Submitted By
Texas Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

"Claims in question were faxed, numerous times. Fax confirmation sheets are included. Furthermore, claims were also mailed, certified, on September 13, 2108, and a copy of signed receipt is attached."

RESPONDENT'S POSITION SUMMARY

"The requestor has waived its right to DWC MDR for dates 9/22/17 and 4/17/18…. Texas Mutual has elected to pay code 99214 for date 7/6/18 under separate cover."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
September 22, 2017 to July 9, 2018	Professional Medical Services	$1,331.00	$55.96

AUTHORITY

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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. The division takes official notice of a typographical error on the requestor's form DWC060 medical fee dispute resolution request – *Table of Disputed Services*, which indicates a disputed service date of July 9, 2018; however, the submitted medical bill and all supporting documentation reference service date July 6, 2018. Accordingly, the division deems the disputed date of service to be July 6, 2018 for the purpose of this review.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - 150 – Payer deems the information submitted does not support this level of service.
   - 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
   - 18 – Exact duplicate claim/service

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 248 – DWC-73 in excess of the filing requirements; no change in work status and/or restrictions. Reimbursement denied per rule 129.5
- 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 724 – No additional payment after a reconsideration of services. For information call 1-800-937-6824
- 736 – Duplicate appeal. Network contract applied by Texas Star Network. Call 800-381-8067 for reconsideration discussion.
- 890 – Denied per AMA CPT Code description for level of service and/or nature of presenting problems.
- 138 – Appeal procedures not followed or time limits not met
- 879 – Rule 133.250(b) - health care provider shall submit the request for reconsideration no later than 10 months from the date of service

Issues

1. Did the requestor waive the right to medical fee dispute resolution?
2. Is the requestor entitled to additional payment?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) requires that a requestor shall timely file the request with the division's MFDR Section or waive the right to medical fee dispute resolution (MFDR).

   Rule §133.307(c)(1)(A) further requires that a request for MFDR that does not meet any exceptions listed in Rule §133.307(c)(1)(B) be filed no later than one year after the dates of service in dispute.

   The disputed dates of service extend from September 22, 2017 to July 9, 2018.

   The request was received in the division's MFDR Section on June 7, 2019.

   This date is later than one year after the disputed dates of service September 22, 2017 and April 17, 2018.

   Review of the submitted information finds the services do not involve issues identified in Rule §133.307(c)(1)(B). Consequently, the MFDR request for dates of service September 22, 2017 and April 17, 2018 was not timely filed with the division. The requestor has thus waived the right to MFDR for these services.

   However, the requestor timely filed the MFDR request for date of service July 6, 2018.
   Accordingly, date of service July 6, 201 is eligible for review.

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 Medicare payment policies modified by DWC rules. The MAR is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the DWC annual conversion factor.

   Reimbursement is calculated as follows:

   - Procedure code 99214, July 6, 2018, has a Work RVU of 1.5 multiplied by the Work GPCI of 1 is 1.5. The practice expense RVU of 1.44 multiplied by the PE GPCI of 0.938 is 1.35072. The malpractice RVU of 0.1 multiplied by the malpractice GPCI of 0.796 is 0.0796. The sum is 2.93032 multiplied by the DWC conversion factor of $58.31 for a MAR of $170.87.

   The total allowable reimbursement for the disputed services is $170.87. The insurance carrier submitted documentation with their response to MFDR to support payment issued of $114.91 (plus $5.09 in interest). The amount remaining due is $55.96. This amount is recommended.

Conclusion

For the reasons above, the division finds the requestor has established that additional reimbursement is due. As a result, the amount ordered is $55.96.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable), based on the submitted information, the division finds the requestor is entitled to additional reimbursement. The division hereby ORDERS the respondent to remit to the requestor $55.96, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	August 16, 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.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). The division must receive the request within twenty days of your receipt of this decision.

The request may be faxed, mailed or personally delivered either to the field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** together with any other information required by 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.