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
UT Health East Texas

Respondent Name
City of Tyler

MFDR Tracking Number
M4-20-0476-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
October 21, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our provider was not advised that this was Work Comp at the time of service. We billed Claims Admin Services and appealed with proof of timely."

Amount in Dispute: $96.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is our position that denial for timely filing should be maintained."

Response Submitted by: Claims Administrative Services Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 28, 2019	99212	$96.00	$71.94

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 the billing requirements for health care claims.
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
   - 18 – Exact duplicate claim/service
   - 350 – Bill has been identified as a request for reconsideration or appeal

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for professional medical services rendered February 28, 2019. The insurance carrier denied the service as not timely submitted.

   Review of the submitted documentation found a notice from HealthFirst dated August 16, 2019 notifying the health care provider of an overpayment as the services were related to a work injury.

   The health care provider submitted a claim to Claims Administrative Services on September 6, 2019. This claim was received by Claims Administrative Services on September 16, 2019.

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

   Based on the above the health care provider did submit the claim to the correct worker's compensation carrier within 95 days of being notified of worker's compensation coverage. The insurance carrier's denial is not supported. The disputed service will be reviewed per applicable fee guideline.

2. 28 TAC §134.203 (c) states system participants shall apply the Medicare payment policies with minimal modifications to determine the MAR for Evaluation & Management. The Medicare allowable for the disputed service is $43.80. The maximum allowable reimbursement is calculated as DWC Conversion factor/Medicare conversion factor multiplied by the Medicare allowable or, 57.19/36.0391 x $43.80 = $71.94.
3. The allowed amount for the service in dispute is $71.94. This amount is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has established payment is due. As a result, the amount ordered is $71.94.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $71.94, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 21, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.