



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

VICTORY MEDICAL AND FAMILY CARE

Respondent Name

ZURICH AMERICAN INSURANCE COMPANY

MFDR Tracking Number

M4-21-0354-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

October 29, 2020

Response Submitted By

Flahive, Ogden & Latson

REQUESTOR'S POSITION SUMMARY

"Can you look into this to see why the interest payment was not included in the payment."

RESPONDENT'S POSITION SUMMARY

"The carrier has reprocessed the provider's bill and is recommending an additional reimbursement of \$474.59 plus interest. If the provider is in agreement with that amount, then we would ask that the provider withdraw his request for Medical Fee Dispute Resolution once he had received payment."

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
November 1, 2019 and November 13, 2019	99204, 72100, 6372, J1885 and 99214	\$519.85	\$0.00
		Interest	\$0.00
TOTAL			\$0.00

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

- 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
- TAC §134.130 sets out the procedures for Interest for Late Payment on Medical Bills and Refunds.
- Texas Labor Code §413.019 sets out the procedures for Interest Earned for Delayed Payment, Refund, or Overpayment regarding medical services and fees. Texas Labor Code §401.023 sets out the procedures for computation of Interest or Discount Rate. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 TAC §134.203 sets out the fee guideline for professional medical services.

Issues

- 1. Did the insurance carrier issue payment for the disputed charges?
- 2. Is the requestor entitled to additional reimbursement and interest?

Findings

- 1. The requestor billed the amount of \$881.12 for CPT code(s) 99204, 72100, 6372, J1885 and 99214, rendered on November 1, 2019 and November 13, 2019. The requestor seeks reimbursement in the amount of \$519.85. Review of the submitted documentation supports that the insurance carrier issued payment for the disputed services. The requestor in correspondence to the Division confirmed receipt of payment for the disputed services, however, seeks payment for the interest from the insurance carrier.

The requestor alleges that interest is due for the service in dispute. Pursuant to 28 TAC §134.130(a) "Insurance carriers shall pay interest on medical bills paid on or after the 60th day after the insurance carrier originally received the complete medical bill, in accordance with 28 TAC §133.240 of this title (relating to Medical Payment and Denials).

28 TAC §134.130(c) states, "The rate of interest to be paid shall be the rate calculated in accordance with Labor Code §401.023 and in effect on the date the payment was made."

28 TAC §134.130 "(d) Interest shall be calculated as follows: (1) multiply the rate of interest by the amount on which interest is due (to determine the annual amount of interest); (2) divide the annual amount of interest by 365 (to determine the daily interest amount); then (3) multiply the daily interest amount by the number of days of interest to which the recipient is entitled under subsection (a) or (b) of this section."

Review of the submitted documentation, supports that the insurance carrier issued interest in the amount of \$14.69 on November 20, 2020 under reference #000008180480657.

- 2. The DWC finds that the disputed services were reimbursed by the insurance carrier and interest was issued in accordance with 28 TAC §134.130(c). As a result, the requestor is not entitled to additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

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

Signature	Medical Fee Dispute Resolution Officer	April 19, 2021 Date
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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, 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 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.