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
Behavioral Health Providers

Respondent Name
City of Fort Worth

MFDR Tracking Number
M4-21-1858-01

Carrier's Austin Representative
Box Number 4

MFDR Date Received
June 17, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The EOB from the carrier is stating denied due to timely filing. The claim was initially billed to Sedgwick on 07/09/2020, timely filed, see attached notice of timely filing. ."

Amount in Dispute: $1,348.51

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Sedgwick is working hard on resolving this system matters internally to ensure a resolution will be promptly response to DWC before and/or on the 14-day extension date of 07/20/2021 is granted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 29, 2020	90791, 96138, 96139, 96130, 96131	$1,348.51	$1,348.51

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 §134.203 sets out the fee guideline for professional services.

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. Did the insurance carrier support payment was made?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier stated in their position statement that a response was to be made prior to 07/20/2021. Review of the submitted documentation found the requestor's position statement is not supported. The services in dispute will be reviewed per applicable fee guidelines.
2. The requestor is seeking reimbursement of professional medical services rendered in June 2020. DWC Rule 28 TAC 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 included and the established conversion factor for the date of service. The Medicare conversion factor for the disputed date of service is $36.0896, the DWC conversion factor is 60.32. The calculated maximum allowable reimbursement is as follows:

Procedure Code	WC Conv	Medicare Conversion Factor	Physician Fee Schedule	Calc per Unit	# of Units	MAR
90791	60.32	36.0896	146.39	$244.68	2	$489.35
96130	60.32	36.0896	123.06	$205.68	1	$205.68
96131	60.32	36.0896	94.39	$157.76	2	$315.53
96138	60.32	36.0896	39.26	$65.62	1	$65.62
96139	60.32	36.0896	39.26	$65.62	5	$328.09

3. The maximum allowable reimbursement per the applicable fee guideline and the physician fee schedule found at www.cms.gov, is $1,404.27. The requestor is seeking $1,348.51. 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 $1,348.51.

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 $1,348.51, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 10, 2021 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.