TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
DONALD GENE EAVES, DC

Respondent Name
ARCH INDEMNITY INSURANCE COMPANY

MFDR Tracking Number
M4-22-0135-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 22, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 2, 2021	99456-W5-NM	$350.00 + interest	$4.57
	Total	$350.00 + interest	$4.57

Requestor's Position

"The reconsideration request has subsequently been ignored as to date we have received no notification that either submission was considered for reimbursement. It is my position that this bill should be reimbursed at its face value of $350.00 as outlined in 134.204 (j) for MMI/IR determination."

Amount in Dispute: $350.00 + interest

Respondent's Position

"The carrier has reconsidered its position and is in agreement that the provider is entitled to reimbursement of $350. We would ask that the Division allow the parties to informally resolved the medical fee dispute and once the provider receives payment that he withdraw his request for medical fee dispute resolution or that the Division dismiss it on the basis that the medical fee dispute will have resolved."

Response Submitted by: Flahive, Ogden & Latson

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 TAC §134.130 sets out the procedures for Interest for Late Payment on Medical Bills and Refunds.
3. TLC §413.019 sets out the procedures for Interest Earned for Delayed Payment, Refund, or Overpayment regarding medical services and fees.
4. TLC §401.023 sets out the procedures for computation of Interest or Discount Rate.

Denial Reasons

The insurance carrier provided a copy of an EOB; however, the EOB did not contain denial reasons or reductions.

Issues

1. Did the insurance carrier issue payment for the disputed charges?
2. What is the date the insurance carrier received the medical bill?
3. What is the interest due per 28 TAC §134.130?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor billed the amount of $350.00 for CPT code(s) 99456-W5-NM, rendered on February 2, 2021. Review of the submitted documentation supports that the insurance carrier issued payments totaling $350.00. The requestor, in correspondence to the Division confirmed receipt of payment for the disputed services, however, seeks payment for the interest not reimbursed by the insurance carrier.
2. 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 §133.240 of this title (relating to Medical Payment and Denials). Review of the submitted documentation establishes that March 22, 2021 is the date the bill was submitted to the insurance carrier. The Division finds that the requestor is entitled to reimbursement for the interest and interest is determined pursuant to 28 TAC §134.130(c) & (d).
3. 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.

28 TAC §134.130 "(e) The percentage of interest for each quarter may be obtained by accessing the Texas Department of Insurance's website, www.tdi.state.tx.us." The Division finds that the percentage rate for this quarter is 3.58%.

4. The respondent reimbursed the requestor the amount of $350.00 for disputed services. In accordance with 28 TAC §134.130, the amount due for interest is $4.57. Therefore, an amount of $4.57 is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The DWC finds the requester has established that reimbursement of $4.57 is due.

Order

Under TLC §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor $4.57 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		January 6, 2022
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.