



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

STEPHANIE JANIAC DC

Respondent Name

STARR SPECIALTY INSURANCE COMPANY

MFDR Tracking Number

M4-22-1320-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

March 1, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 15, 2021	99456-W5-WP	\$0.00	\$0.00
	Interest	\$1.28	\$1.28
Total		\$1.28	\$1.28

Requestor's Position

The requestor did not submit a position summary for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Amount in Dispute Interest: \$1.28

Respondent's Position

"...the carrier has reconsidered its position and has issued payment in the amount of \$650. We would ask that once the provider receives payment that she withdraw her request for medical fee dispute resolution 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 reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 1002 – DUE TO AN ERROR IN PROCESSING THE ORIGINAL BILL, WE ARE RECOMMENDING FURTHER PAYMENT BE MADE FOR THE ABOVE NOTED PROCEDURE.
- 2008 - ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
- P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- W3 - BILL IS A RECONSIDERATION OR APPEAL.

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 \$650.00 for CPT code 99456-W5-WP, rendered on April 15, 2021. Review of the submitted documentation supports that the insurance carrier issued payments totaling \$650.00. 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. 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 §133.240 of this title (relating to Medical Payment and Denials).

Review of the submitted documentation (EOBs) concludes that the date the carrier originally received the complete medical bill is December 30, 2021. The Division finds that the requestor is entitled to reimbursement for the interest 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 3.77%.
4. The respondent reimbursed the requestor the amount of \$650.00 for disputed services. In accordance with 28 TAC §134.130, the amount due for interest is \$1.28. Therefore, an amount of \$1.28 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 \$1.28 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 \$1.28 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 24, 2022 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 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 electrónico CompConnection@tdi.texas.gov.