Division of Workers' Compensation
11PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
NORTH TEXAS PAIN RECOVERY

Respondent Name
LIBERTY INSURANCE CORPORATION

MFDR Tracking Number
M4-23-0626-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
November 10, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 9, 2021 through January 6, 2022	97799-CP-CA	$11,200.00	$0.00
	Interest	Interest	$416.86
	Total	$11,200.00	$416.86

Requestor's Position

"No interest was paid as the bills were initially denied correctly as the provider does not have a contract with Coventry HCN. However, payments were issued as the Case Manager gave retro-active approval for this out of network treatment on those DOS."

Amount in Dispute: Interest

Respondent's Position

"The bill has been reviewed and adjusted for payment – copies of EOBs are submitted for your review."

Response Submitted by: Liberty Mutual

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.
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

Since the insurance company has already paid for the services in question, there are no refusal reasons to be addressed in this dispute.

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 $11,200.00 for CPT code 97799-CP-CA, rendered on December 9, 2021 through January 6, 2022. The Requestor sought reimbursement in the amount of $11,200.00. Review of the submitted documentation supports that the insurance carrier issued payments totaling $8,000.00. The requestor in correspondence to the Division confirmed receipt of payment for the disputed services, however, seeks payment for the interest not included in the late payment of the disputed services.

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) establishes the receipt date of the medical bill.

DOS	CPT	# UNITS	AMT BILLED	MAR	BILL REC'D DATE	PAID DATE	AMT PAID	INTEREST DUE
12/9/21	97799-CP-CA	8	$1400	$1000	1/13/22	11/16/22	$1000	$50.69
12/10/21	97799-CP-CA	8	$1400	$1000	1/13/22	11/16/22	$1000	$50.69
12/13/21	97799-CP-CA	6	$1050	$750	12/28/21	11/16/22	$750	$40.47
12/14/21	97799-CP-CA	6	$1050	$750	12/28/21	11/16/22	$750	$40.47
12/15/21	97799-CP-CA	8	$1400	$1000	12/28/21	11/16/22	$1000	$53.96
12/16/21	97799-CP-CA	8	$1400	$1000	12/28/21	11/16/22	$1000	$53.96
12/17/21	97799-CP-CA	8	$1400	$1000	12/28/21	11/16/22	$1000	$53.96
1/5/22	97799-CP-CA	4	$700	$500	1/24/22	11/16/22	$500	$24.22
1/6/22	97799-CP-CA	8	$1400	$1000	1/24/22	11/16/22	$1000	$48.44
TOTAL		64	$11,200	$8,000			$8,000	$416.86

3. The Division, therefore, concludes that the date the carrier originally received the complete medical bills is indicated above. The Division finds that the requestor is entitled to reimbursement for the interest pursuant to 28 TAC §134.130(c) & (d).

   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 7.46%.

4. The respondent reimbursed the requestor the amount of $8,000.00 for the disputed services. In accordance with 28 TAC §134.130, the amount due for interest is $416.86. Therefore, the amount of $416.86 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 $416.86 is due.

Order

Under TLC §§413.031 and 413.019, the DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor $416.86 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

____________________	____________________	April 25, 2023
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.