Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Lubbock Artificial Limb & Brace

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-12-3557-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
August 13, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "There were 2 different claims mailed together in the same envelope for the same dates of service. One in the amount of $1,586.00 and the other for $15,889.00. Please keep in mind, both claims are different bills. I received payment on December 6, 2011, in the amount of $1,586.00."

Amount in Dispute: $15,889.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…the Office performed an in-depth review of the requestor's billing and determined that the will maintain our denial for 29-Time limit for filing has expire."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 31, 2011	Prosthetic	$15,889.00	$15,889.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 §133.20 sets out requirements for medical bill submission by health care providers.
3. 28 Texas Administrative Code §134.202 sets out the medical fee guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29 – The time limit for filing has expired
   - 193 – Original payment decision is being maintained

Issues

1. Did the requestor support the claim was filed in timely manner?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.20(b) states, "Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." Review of the information submitted by the requestor finds;
    a. Medical claim showing submission date 11/4/2011
    b. Notes from phone calls made to carrier shows that within 95 day time frame the carrier acknowledged receipt of the claim and after leaving three messages was told "still in process"

   Therefore, the Division finds the requestor provided evidence of timely submission of the medical bill and the claims will be processed per applicable rules and fee guidelines.
2. Per 28 Texas Administrative Code §134.202 (2) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthethics, Orthotics and Supplies (DMEPOS) fee schedule; Medical Fee Guideline(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications:…" The maximum allowable reimbursement (MAR) will be calculated as follows;

Date of Service	Submitted Code	Submitted Charge	MAR DMEPOS Fee Schedule multiplied by 125%
October 31, 2011	L5940	724.00	602.66 X 125% = $753.33
October 31, 2011	L5629	459.00	381.82 X 125% = $477.28
October 31, 2011	L5645	865.00	722.43 X 125% = $903.04
October 31, 2011	L5987	7873.00	6554.56 X 125% = $8,193.20
October 31, 2011	L5984	728.00	605.81 X 125% = $757.26
October 31, 2011	L5301	2985.00	2485.13 X 125% = $3,106.41
October 31, 2011	L5668	292.00	121.32 X 125% = $151.65
October 31, 2011	L5671	622.00	518.08 X 125% = $647.60
October 31, 2011	L5620	401.00	334.02 X 125% = $4,175.25
October 31, 2011	L5637	417.00	347.08 X 125% = $433.85
October 31, 2011	L5910	523.00	435.14 X 125% = $543.93
	TOTAL	$15,889.00	$20,142.80

3. The total recommended payment for the services in dispute is $20.142.80. This amount less the amount previously paid by the insurance carrier of $0.00. The requestor is seeking $15,889.00. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $15,889.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $15,889.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		November 19, 2014
Signature	Medical Fee Dispute Resolution Officer	Date
		November 19, 2014
Signature	Medical Fee Dispute Resolution Manager	Date

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, 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 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 MDR 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.