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
SUMMIT REHABILITATION CENTERS

Respondent Name
LIBERTY INSURANCE CORPORATION

MFDR Tracking Number
M4-06-5215-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
March 20, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DOS 10/25/05 through 11/1/05): According to TWCC, the provider followed all fee guidelines."

Amount in Dispute: $4,491.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Procedure code of 99213 for dates of 10/25/05, 10/26/05, 10/28/05, and 11/01/05 has been paid per fee guidelines @ $65.44; however, due to no W-9 on file from provider 28% withholding was subtracted. Please see attached explanation regarding withholding."

Response Submitted by: Sandy Adamson, Liberty Mutual, 2875 Browns Bridge Road, Gainesville, Georgia 30504

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 23, 2005 to December 21, 2005	Rehabilitation Services	$2,100.82	$73.28

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 §133.308 sets out procedures for independent review of medical necessity disputes.
3. 28 Texas Administrative Code §133.304 sets requirements for insurance carriers regarding medical payments and denials.
4. 28 Texas Administrative Code §134.202 sets out the fee guidelines for professional medical services.
5. The requestor submitted an amended *Table of Disputed Services* dated August 28, 2008. The Division will consider the remaining disputed services as indicated in the requestor's amended table as the basis for this review. The amount in dispute will be deemed to be the amount as listed on the requestor's revised table.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - X375 – "UNNECESSARY MEDICAL TREATMENT OR SERVICE."

- X435 – "BASED ON PEER REVIEW, FURTHER TREATMENT IS NOT RECOMMENDED."
- Z560 – "THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE OR USUAL AND CUSTOMARY ALLOWANCE."

Findings

1. Are there unresolved issues of medical necessity?
2. What is the maximum allowable reimbursement (MAR) for the services in dispute?
3. Did the insurance carrier meet the requirements of §133.304(c)?
4. Did the insurance carrier raise new denial reasons or defenses in its response?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed dates of service August 23, 2005 through October 21, 2005, and November 3, 2005 through November 21, 2005 with reason codes X375 – "UNNECESSARY MEDICAL TREATMENT OR SERVICE" and X435 – "BASED ON PEER REVIEW, FURTHER TREATMENT IS NOT RECOMMENDED." Per 28 Texas Administrative Code §133.305(a)(2), effective January 1, 2003, 27 *Texas Register* 12282, "Medical Fee Disputes involve a dispute over the amount of payment for health care rendered to an injured employee and determined to be medically necessary and appropriate for treatment of that employee's compensable injury. The dispute is for reasons other than the medical necessity of the care (e.g. based upon the requirements of commission rules or fee guidelines)." Per 28 Texas Administrative Code §133.307(g)(2), effective January 1, 2003, 27 *Texas Register* 12282, "If the request contains unresolved medical necessity issues, the commission shall notify the parties of the review requirements pursuant to §133.308." The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that there are unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution, therefore these disputed services will not be considered in this review. The request for resolution of the remaining disputed services, for dates of service from October 25, 2005 through November 11, 2005, does not contain unresolved issues related to medical necessity; therefore, these services will be considered in this review.
2. This dispute relates to professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.202(c)(1), effective January 5, 2003, 27 *Texas Register* 4048 and 12304, which requires that to determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: "for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%." Reimbursement is calculated as follows:
   - Procedure code 99213, service date October 25, 2005, has a Medicare payment rate of $52.35. This amount multiplied by 125% results in a MAR of $65.44.
   - Procedure code 99213, service date October 26, 2005, has a Medicare payment rate of $52.35. This amount multiplied by 125% results in a MAR of $65.44.
   - Procedure code 99213, service date October 28, 2005, has a Medicare payment rate of $52.35. This amount multiplied by 125% results in a MAR of $65.44.
   - Procedure code 99213, service date November 11, 2005, has a Medicare payment rate of $52.35. This amount multiplied by 125% results in a MAR of $65.44.
3. The total recommended payment is $261.76. Review of the submitted explanations of benefits finds that the insurance carrier paid $188.48. Without explanation of the reason for the reduction of payment, the insurance carrier withheld $18.32 per date of service for a total reduction or withholding of $73.28 from the amount due to the health care provider. The Division's former rule at 28 Texas Administrative Code §133.304(c), effective July 15, 2000, 25 *Texas Register* 2115, addressed actions that the insurance carrier was required to take at the time it made or denied payment on a bill. Review of the submitted explanations of benefits finds that the insurance carrier has failed to meet the requirements of §133.304(c).
4. The respondent's supplemental response to the Division by facsimile transmission, dated May 18, 2006, states "On an annual basis, the IRS notifies the company of all recipients whose name and Tax Identification Number (TIN) as reported on a Form 1099-MISC or Form 1099-INT do not match IRS records. . . . We mail a

form to providers on this list giving them the opportunity to supply us with correct information. We are required to withhold 28% from all future payments for providers that do not respond to our request." The respondent provided no documentation to support that the insurance carrier was required by the IRS to withhold payments for this particular health care provider, or that the health care provider had been given notice or the opportunity to respond to such a requirement, or in fact had failed to do so. Regardless, this new explanation for the insurance carrier's reduction of payment may not be raised after the filing of a request for medical fee dispute resolution. Per 28 Texas Administrative Code §133.307(j)(2), effective January 1, 2003, 27 *Texas Register* 12282, "The response shall address only those denial reasons presented to the requestor prior to the date the request for medical dispute resolution was filed with the division and the other party. Responses shall not address new or additional denial reasons or defenses after the filing of a request. Any new denial reasons or defenses raised shall not be considered in the review." No documentation was found to support that the insurance carrier presented the above denial reason to the requestor prior to the date the request for medical dispute resolution was filed. Consequently, the insurance carrier has waived the right to raise this new denial reason or defense during dispute resolution. The disputed services will therefore be reviewed for payment according to applicable Division rules and fee guidelines.

5. As determined above, the total MAR for the disputed services is $261.76. The insurance carrier has paid $188.48, leaving a balance due to the requestor of $73.28. 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 $73.28.

ORDER

Based on 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 in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $73.28 plus applicable accrued interest per 28 Texas Administrative Code §134.803, and/or §134.130 if applicable, due within 30 days of receipt of this Order.

Authorized Signature

Signature — Grayson Richardson, Medical Fee Dispute Resolution Officer — Date: May 2, 2014

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.