



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

INJURY 1 TREATMENT CENTER

**Respondent Name**

XL SPECIALTY INSURANCE CO

**MFDR Tracking Number**

M4-11-3516-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

June 14, 2011

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Carrier recommended payment but never sent check, claim still outstanding."

**Amount in Dispute:** \$550.16

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The EOBs raise underlying issues of casual relation. In particular, the EOBs indicate that the treatments underlying the charges in dispute were for body parts and/or conditions not related to the compensable injury."

**Response Submitted by:** Flahive, Ogden & Latson

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 1, 2010 through September 24, 2010	90806	\$550.16	\$550.16

#### 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 §134.203 sets out the fee guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
  - 593 – Payment for this service is always subsumed or bundled into payment for another service, no separate payment is made.
  - 663 – Reimbursement has been calculated according to the state fee schedule guidelines.
  - 900 – Based on further review, no additional allowance is warranted.
  - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment.

- W1 – Workers Compensation State Fee Schedule Adjustment.
- Bill Notes: Medicare guidelines indicate that payment for procedure codes indicated as bundled is always subsumed or bundled into payment for another service and no separate payment is made. Therefore, if a procedure code indicated as bundled is billed, it will be denied. Some codes on the Medicare list have state specific guidelines and are therefore not on this rule.

## **Issues**

1. Did the respondent submit copies of the EOBs denying casual relation?
2. Did the requestor bill in conflict with the NCCI?
3. Is the requestor entitled to reimbursement?

## **Findings**

1. To determine whether an extent-of-injury or related dispute existed at the time any particular medical fee dispute was filed with the Division and whether it was related to the same service, the applicable former version of 28 Texas Administrative Code §133.240(e)(1), (2)(C), and (g) addressed actions that the insurance carrier was required to take, during the medical billing process, when the insurance carrier determined that the medical service was not related to the compensable injury: 31 TexPeg 3544, 3558 (April 28, 2006).

Former 28 Texas Administrative Code §133.240(e) (1), (2) (C), and (g): The insurance carrier shall send the explanation of benefits in the form and manner prescribed by the Division.... The explanation of benefits shall be sent to: (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill; and (2) the injured employee when payment is denied because the health care was: ... (C) unrelated to the compensable injury, in accordance with 28 Texas Administrative Code §124.2 of this title, ... (g) An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code §409.021, and §124.2 and 124.3 of this title ... if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that: . . (3) the condition for which the health care was provided was not related to the compensable injury.

Review of the submitted documentation finds that the insurance carrier has not meet the requirements of 28 Texas Administrative Code §133.240. The insurance carrier refers to EOB denials containing underlying issues of casual relation; however, the division did not find copies of EOBs contained in the dispute request/response. The division therefore finds that the carrier's denial raised in the position summary is not supported. As a result, the disputed charges are reviewed pursuant to the applicable laws and rules.

2. Per 28 Texas Administrative Code §134.203 “(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.”

Review of the submitted documentations finds that the requestor billed CPT codes 90806 and 90889 on September 1, 2010 through September 24, 2010. The requestor seeks reimbursement for CPT code 90806. The division completed NCCI edits to identify edit conflicts that may affect reimbursement. The following was identified:

No NCCI edits conflicts were identified for disputed CPT code 90806. As a result, the division will determine reimbursement pursuant to 28 Texas Administrative Code §134.203.

3. Per 28 Texas Administrative Code §134.203 “(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year.”

Per 28 Texas Administrative Code §134.203 “(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title.”

Review of the submitted documentation finds that the MAR for CPT code 90806 is \$137.54. The requestor is therefore entitled to reimbursement for dates of service September 1, 2010, September 9, 2010, September 17, 2010 and September 24, 2010 in the amount of \$137.54/date of service x 4 dates of service = \$550.16. 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 \$550.16.

**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 \$550.16 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

Signature	Medical Fee Dispute Resolution Officer	June 23, 2014 Date
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**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.**