**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**
Fredrick W Kersh

**Respondent Name**
New Hampshire Insurance Co

**MFDR Tracking Number**
M4-13-1519-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
February 12, 2013

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "It is my position that I have wasted more than what the claim would pay in my time and efforts to try to get this claim processed with no help from the adjustor or her supervisor and still no real definition of what would be done."

**Amount in Dispute:** $122.86

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The carrier has denied reimbursement for the services, and submits the fee reductions were consistent with the applicable fee guidelines. The carrier also notes the diagnosis is inconsistent with the services rendered. The carrier has attached a copy of the report from Dr. Hood, who opined that the claimant's compensable injury resolved within 3 months of the date of injury. The date of service for the disputed charges is more than fourteen (14) months after the date of injury. Thus, the services in question are 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 |
|---|---|---|---|
| July 11, 2012 | 99218, 99080 – 73 | $122.86 | $122.86 |

## *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 the fee guidelines for professional medical services.
3. 28 Texas Administrative Code §129.5 sets out guidelines for work status reports.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 11 – The diagnosis is inconsistent with the procedure.
   - W1 – Workers Compensation State Fee Schedule Adjustment

**Issues**

1. Did the respondent raise a new denial reason?
2. Was the reported diagnosis related to services provided?
3. Is the requestor entitled to reimbursement?

**Findings**

1. In its response to medical fee dispute resolution, the respondent states that "Thus, the services in question are not related to the compensable injury." Applicable 28 Texas Administrative Code §133.307 (d)(2)(B) states "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." No documentation was found to support that the carrier responded via an explanation of benefit with this denial reason prior to the request for MFDR. The division concludes that the carrier raised a new denial reason. For that reason, the carrier's position regarding compensability shall not be considered in this review.
2. The carrier denied the disputed services as, 11 – "The diagnosis is inconsistent with the procedure." Review of the submitted medical bill finds the International Classification of Disease (ICD) 9 code used to report diagnosis was 847.2 – "Sprains and strains of other and unspecified parts of back, lumbar". Review of submitted documentation titled "Notice of Disputed Issue(s) and Refusal to Pay Benefits" dated February 7, 2013,) states, "…the compensable injury which is limited to lumbar sprain/strain…" Therefore, the submitted diagnosis on the medical bill is accepted as compensable injury. The carrier's denial is not supported. The disputed services will be reviewed per applicable rules and fee guidelines.

3. 28 Texas Administrative Code §134.203(c) states in pertinent part, 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 (current year conversion factor) or (MAR) = (TDI-DWC Conversion Factor / Medicare conversion factor) x Medicare Price. The Division finds this calculation to be as follows for service in dispute (54.86 / 34.0376) x 66.92 = $107.86. The requestor also submitted a charge for 99080 – 73. 28 Texas Administrative Code §129.5 states in pertinent part, "(i) Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15. A doctor shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section;" Review of the medical bill finds the requestor billed in compliance with Rules 134.203 and 129.5. The total Maximum Allowable Reimbursement (MAR) is $107.86 + $15.00 for Work Status Report = $122.86. 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 $122.86.

***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 $122.86 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

**Authorized Signature**

| | | June 23, 2014 |
|---|---|---|
| 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 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**.