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
Michael Putney MD

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-13-2181-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 30, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement included with documentation.

Amount in Dispute: $2,111.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier submits that the treatment underlying the disputed charges was unnecessary and unrelated to the accepted contusion/abrasion injury… If the treatment was appropriate, it was appropriate for the pre-existing problems in the claimant's right knee, and not the compensable contusion/abrasion. Thus, no reimbursement is due."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 21, 24, 28 – 2013 and February 25, 2013	Physician Services	$2,111.00	$540.27

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 fee guidelines for medical professional services.
3. 28 Texas Administrative Code §129.5 sets our fee guidelines for work status reports.
4. 28 Texas Administrative Code §134.600 sets out requirements for prior authorization of medical services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation Jurisdictional Fee Schedule Adjustment

Issues

1. Did the respondent raise a new issue?
2. Did the requestor submit disputed charges in compliance with division guidelines?

3. Was prior authorization required?
4. Is the requestor entitled to reimbursement?

Findings

1. In its response to medical fee dispute resolution, the respondent states that "The carrier submits that the treatment underlying the disputed charges was unnecessary and unrelated to the accepted contusion/abrasion injury." Applicable 28 Texas Administrative Code §133.307 (d)(2)(F) 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." Review of the Explanation of Benefits from the Carrier finds use of only "W1 – Workers' compensation jurisdictional fee schedule adjustment" as the denial explanation code. The division concludes that the respondent raised a new denial reason. For that reason, the carrier's position regarding the treatment being, "unnecessary and unrelated to the accepted contusion/abrasion injury," shall not be considered in this review.
2. The services in dispute include CPT code 99214 for the office visits. 28 Texas Administrative Code §134.203(c)(1) states in pertinent parts, (c)"To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications." (c) (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 found at www.cms.hhs.gov)." The Maximum Allowable Reimbursement (MAR) calculation is as follows: (2013 DWC Conversion Factor / Medicare Conversion Factor) x Non-Facility Price or as found below. 28 Texas Administrative Code §129.5H(h)(i)(1) states in pertinent part, "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…" ,,,"The amount of reimbursement shall be $15." The division finds the requestor submitted the disputed charge in compliance with division rules. The carrier's denial is not supported.

Date of Service	Submitted Code	Amount Billed	MAR	Amount Paid	Amount Due to Provider
January 21, 2013	99214	$298.00	(55.3 / 34.023) x 101.57 = $165.09	0.00	$165.09
January 21, 2013	99080	$15.00	$15.00	0.00	$15.00
January 28, 2013	99214	$298.00	(55.3 / 34.023) x 101.57 = $165.09	0.00	$165.09
January 28, 2013	99080	$15.00	$15.00	0.00	$15.00
February 25, 2013	99214	$298.00	(55.3 / 34.023) x 101.57 = $165.09	0.00	$165.09
February 25, 2013	99080	$15.00	$15.00	0.00	$15.00
	TOTAL	$939.00		0.00	$540.27

3. Review of the submitted documentation finds authorization was obtained for physical therapy and Voltaren 1%. The MRI submitted under code 73721 was not authorized. 28 Texas Administrative Code §134.600(p)(12) states in pertinent part, (p) "Non-emergency health care requiring preauthorization includes: (12) "treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier." The disputed service required authorization but no supporting documentation was found to support authorization was obtained.

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 $540.27.

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 $540.27 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		June 25, 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.