



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

David R Kaiser

Respondent Name

Northside ISD

MFDR Tracking Number

M4-13-2370-01

Carrier's Austin Representative

Box Number 16

MFDR Date Received

May 16, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I have made several attempts to get these services paid and they continued to get denied for frivolous reasons."

Amount in Dispute: \$697.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent would show that Requestor is not entitled to reimbursement for the services at issue, because such services should have been processed through the Pre-Auth Utilization Department. The initial muscle testing was performed on 1/12/2012 by Larry Martinez, DC; therefore the muscle testing performed on 10/18/2012 by David Kaiser, DC was a repeat which required Pre-authorization. Since the provider did not follow the appropriate protocol process, the Self-Insured is not liable for payment at this time."

Response Submitted by: Sedgwick, 9601 McAllister Free, Suite 500, San Antonio, Texas 78216

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 18, 2013	95831, 95832, 95851, 99080, 99199-22	\$697.25	\$678.46

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 reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 309 – The charge for this procedure exceeds the fee schedule allowance.
 - W1 – Workers compensation state fee schedule adjustment.
 - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another

service/procedure that has already been adjudicated.

- 86 – Service performed was distinct or independent from other services performed on the same day.
- 216 – Based on the finding of a review organization.
- 193 – Original payment decision is being maintained.

Issues

1. Did the requestor submit the claim per Division rules?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. The respondent in their position statement state, “because such services should have been processed through the Pre-Auth Utilization Department. The initial muscle testing was performed on 1/12/2012 by Larry Martinez, DC; therefore the muscle testing performed on 10/18/2012 by David Kaiser, DC was a repeat which required Pre-Authorization. Since the provider did not follow the appropriate protocol process, the Self-Insured is not liable for payment at this time.” 28 Texas Administrative Code §134.600 (p) states in pertinent part, “Non-emergency health care requiring preauthorization includes: (8) unless otherwise specified in this subsection, a repeat individual diagnostic study: (A) with a reimbursement rate of greater than \$350 as established in the current Medical Fee Guideline;...” Review of the submitted medical bill finds each of the submitted CPT codes has a Fee Guideline reimbursement rate of less than \$350. Therefore prior authorization was not required.
2. Per 28 Texas Administrative Code §134.203(b) (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. The Medicare National Correct Coding Initiative shows an edit exists between code 95832 and 95851. These two procedures are not separately payable. The requestor also billed code 99080 and 99199 both codes to reflect reports. No evidence of any reports was found to support the submission of these charges. No payment can be recommended for 95851, 99080 or 99199.
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 (date of service yearly conversion factor).” The services in dispute will be calculated as found below;
 - Procedure code 95831, service date October 18, 2012, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.28 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.28. The practice expense (PE) RVU of 0.52 multiplied by the PE GPCI of 0.912 is 0.47424. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.809 is 0.02427. The sum of 0.77851 is multiplied by the Division conversion factor of \$54.86 for a MAR of \$42.71 at 14 units is \$597.94.
 - Procedure code 95832, service date October 18, 2012, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.29 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.29. The practice expense (PE) RVU of 0.46 multiplied by the PE GPCI of 0.912 is 0.41952. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.809 is 0.02427. The sum of 0.73379 is multiplied by the Division conversion factor of \$54.86 for a MAR of \$40.26 at 2 units is \$80.52.
 - Per Medicare policy, procedure code 95851, service date October 18, 2012, may not be reported with procedure code 95831 billed on this same claim.
4. The total allowable reimbursement for the services in dispute is \$678.46. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$678.46. 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 \$678.46.

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 \$678.46 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

	Peggy Miller	September , 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.