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 and Address

STEPHEN GIST MD
5931 DESCO DRIVE
DALLAS TX 75235

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-14-0789-01

MFDR Date Received
November 7, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient was preauthorized for Physical Rehabilitation services; he also participated in the Work Hardening Program and these were also preauthorized. As such, regular office visits were medically necessary to manage the patient's care. It is our position that the insurance carrier is delaying payment of the claims that were rendered and preauthorized."

Amount in Dispute: $1,360.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "ESIS Med Bill Impact's Bill Review Department reviewed the above mentioned date of service and found that the provider was not due additional money. It has been determined that ESIS Med Bill Impact will stand on the original recommendation of $0.00. Per the Claims Adjuster, this is unnecessary treatment."

Response Submitted by: ACE ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 21, 2013, March 30, 2013 and April 27, 2013	99080-73	$45.00	$45.00
	G0431-QW-59, 99082 and 99213	$1,315.00	$0.00
		$1,360.00	$45.00

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 a medical fee dispute.
2. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
3. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

4. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).
5. 28 Texas Administrative Code §129.5 sets out the procedure for the Work Status Reports.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - W11 – Entitlement to benefits
   - 50 – Unnecessary treatment w/o peer review
   - 1 – Original DCN 8574634
   - 1 – Previous recommended payment amount on line: $0
   - 2 – This procedure on this date was previously reviewed
   - 18 – Duplicate claim/service

Issues

1. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?
3. Is the requestor entitled to reimbursement for CPT codes 99080-73?

Findings

1. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury.

   28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding... medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding... medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021."

   28 Texas Administrative Code §133.307(e) (3) (G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General).

   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 for CPT codes 99213, G0431 and 99082 rendered on January 21, 2013, March 30, 2013 and April 27, 2013.
2. The requestor has failed to support that the CPT codes 99213, G0431 and 99082 rendered on January 21, 2013, March 30, 2013 and April 27, 2013 are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307. The division finds that the requestor has failed to establish that the respondent's denial of payment reasons concerning medical necessity have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment for CPT codes 99213, G0431 and 99082 rendered on January 21, 2013, March 30, 2013 and April 27, 2013. As a result, no amount is ordered for these services.
3. Per 28 Texas Administrative Code §129.5 "(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 submitted documentation finds that the requestor seeks reimbursement for CPT code 99080-73 rendered on January 21, 2013, March 30, 2013 and April 27, 2013. The requestor submitted documentation to support the billing of the DWC-73's – Texas Workers' Compensation Work Status Reports, as a result, the requestor is entitled to reimbursement in the amount of $15.00 for each date of service, January 21, 2013, March 30, 2013 and April 27, 2013 for a total recommended amount of $ 45.00.

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 $45.00.

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 $45.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		January 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).