



**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**

Peter E Grays

**Respondent Name**

Employers Insurance Co of Wausau

**MFDR Tracking Number**

M4-14-1519-01

**Carrier's Austin Representative**

Box Number 01

**MFDR Date Received**

January 27, 2014

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "I do understand that prior to this surgical service, these services were not pre authorized and since I was unaware that this was going to be indicated during this surgical session until the patient is in the operating room under anesthesia. Therefore an exception to pre authorization of these services should be waived as it was only indicated as necessary once in the operating room I would of not of known prior to the surgical incision that this medial biologic product would be needed for adequate closure."

**Amount in Dispute:** \$3,050.00

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Liberty Mutual believes that Dr. Peter Grays has been appropriately reimbursed for services rendered to (claimant) for the August 2, 2013 date(s) of service."

**Response Submitted by:** Liberty Mutual, 303 Jesse Jewell Parkway, S.E., Suite 500, Gainesville, GA 30501

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 2, 2013	55520, 64774, 15271, 152777	\$3,050.00	\$339.65

**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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - Z710 – the charge for this procedure exceeds the fee schedule allowance
  - 193 – Original payment decision is being maintained
  - X901 – Documentation does not support level of service billed
  - X170 – Pre-authorization was required, but not requested for this service per DWC rule 134.600

## **Issues**

1. Did the requestor support the level of service billed?
2. Did and exception to prior authorization exist?
3. Is the requestor entitled to reimbursement?

## **Findings**

1. The carrier denied the disputed service as, X901 – “Documentation does not support level of service billed.” 28 Texas Labor Code §134.203 states in pertinent part, “(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 codes find the following;
  - Procedure code 55520, 59 – Add on code, this separate procedure by definition is usually a component of a more complex service and is not identified separately. When performed alone or with other unrelated procedures/services it may be reported.Review of the “Operative Report” dated August 2, 2013 finds not documentation to support separate incision or procedure was performed. The carrier’s denial is supported.
2. The carrier denied CPT codes, 15271 and 15777 as X170 –“Pre-authorization was required, but not requested for this service per DWC rule 134.600.” 28 Texas Labor Code §134.600 (p) states in pertinent part, “(p) Non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay; (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section; and 28 Texas Labor Code §134.600 (c) states, “The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions); (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care; (C) concurrent utilization review of any health care listed in subsection (q) of this section that was approved prior to providing the health care; or (D) when ordered by the commissioner; Review of the submitted documents found prior authorization was required and no exceptions are present. The carrier’s denial is supported.
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... For Surgery when performed in a facility setting, the established conversion factor to be applied is (date of service yearly conversion factor).”
  - Procedure code 49507, service date August 2, 2013, 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 9.09 multiplied by the geographic practice cost index (GPCI) for work of 1 is 9.09. The practice expense (PE) RVU of 6.36 multiplied by the PE GPCI of 0.912 is 5.80032. The malpractice RVU of 1.92 multiplied by the malpractice GPCI of 0.809 is 1.55328. The sum of 16.4436 is multiplied by the Division conversion factor of \$69.43 for a MAR of \$1,141.68.
  - Per Medicare policy, procedure code 55520, service date August 2, 2013, may not be reported with procedure code 49507 billed on this same claim. Modifier and documentation did not support separate procedure.
  - Procedure code 64774, service date August 2, 2013, 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 5.8 multiplied by the geographic practice cost index (GPCI) for work of 1 is 5.8. The practice expense (PE) RVU of 5.67 multiplied by the PE GPCI of 0.912 is 5.17104. The malpractice RVU of 1.05 multiplied by the malpractice GPCI of 0.809 is 0.84945. The sum of 11.82049 is multiplied by the Division conversion factor of \$69.43 for a MAR of \$820.70. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is \$750.00.
  - Per Medicare policy, procedure code 15271, service date August 2, 2013, was not prior authorized.

Provisions of 134.600(p) not met. No separate payment can be recommended.

- Per Medicare policy, procedure code 15277, service date August 2, 2013, was not prior authorized. Provisions of 134.600(p) not met. No separate payment can be recommended.

4. The total allowable reimbursement for the services in dispute is \$1,891.68. This amount less the amount previously paid by the insurance carrier of \$1,552.03 leaves an amount due to the requestor of \$339.65. 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 \$339.65.

**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 \$339.65 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

\_\_\_\_\_  
September 30, 2014  
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.**