



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

TX Health DBA Injury 1 - Dallas

Respondent Name

American Zurich Insurance Co

MFDR Tracking Number

M4-15-0413-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

September 29, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...it is our position that Zurich American Insurance has established an unfair and unreasonable time frame in paying for the services that were medically necessary and rendered to (claimant)."

Amount in Dispute: \$771.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 24 through November 21, 2013	90837	\$771.16	\$385.58

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 §134.600 sets out the guidelines for prospective and concurrent review of health care.
- 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 197 – Precertification/authorization/notification absent
 - 38 – Services denied at the time authorization/pre-certification was requested
 - 218 – Based on entitlement to benefits

Issues

1. Did the requestor resolve the entitlement to benefit issues raised for dates of service November 14, 2013 and November 21, 2013?
2. Did the requestor obtain prior authorization for individual psychotherapy?
3. What is the rule that pertains to applicable fee guideline?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied dates of service November 14, 2013 and November 21, 2013 based on denial reason code "218– Based on entitlement to benefits," during the medical bill review process. The dates of service referenced above contain unresolved issues of eligibility for the same service(s) for which there is a medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) responses during the medical bill review process.

Dispute resolution sequence: 28 Texas Administrative Code §133.305(b) requires that eligibility disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(c) (2) (K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute.

Eligibility dispute process: The Division hereby notifies the requestor that the appropriate process to resolve the issue(s) of extent of injury, including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1. As a result, dates of service November 14, 2013 and November 21, 2013 were not considered in this review.

2. The Carrier denied the disputed services as "197 – Precertification/authorization/notification absent" and "39 – Services denied at the time authorization/pre-certification was requested." Per 28 Texas Administrative Code §134.600 (p) Non-emergency health care requiring preauthorization include (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to: (i) Modalities, both supervised and constant attendance; (ii) Therapeutic procedures, excluding work hardening and work conditioning.." Review of the submitted documentation finds;
 - a. Document dated October 14, 2013 from Zurich Services Corporation which states
 - i. We have authorized the treatment(s) listed below: Additional Services Authorized: Extension: Individual Psychotherapy
 - ii. Current Authorization Period: 10/14/2013 – 12/13/2013 (6 visits)
 - iii. New Total number of Service 12 visits

The Carrier's denial is not supported. The services in dispute will be reviewed per applicable rules and fee guidelines.

3. 28 Texas Administrative Code §134.20 (c) states, "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 maximum allowable reimbursement will be calculated as follows; (TDI-DWC conversion factor / Medicare conversion factor) x Non-facility price = MAR or 55.3 / 34.023 x \$128.55 = \$208.94 each for dates of service October 24, 2013 and November 7, 2013.

Date of service	MAR	Amount in Dispute
October 24, 2013	\$192.79	\$192.79
November 7, 2013	\$192.79	\$192.79
Total		\$385.58

4. The total allowable for the services eligible for dispute is \$385.58. The requestor is seeking \$385.58 for the eligible dates of service in dispute. 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 \$385.58.

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 \$385.58 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		April , 2015
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.