



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Luis F. Puig, M.D.

Respondent Name

Arch Insurance Company

MFDR Tracking Number

M4-15-2615-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

April 13, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "... bills and supporting documentation were sent on a timely matter. After [third party administrator] was contacted, they claimed they did not receive our original bills, therefore we resent all documentation along with proof of timely filing for consideration on December 16, 2014. ... we have not received payment nor an Explanation of Review..."

Amount in Dispute: \$316.84

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on April 23, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 14, 2015	Evaluation & Management, new patient (99203) Radiology, lumbosacral, 4 views (72110) Lumbar orthosis (L0625) Work Status Report (99080) Miscellaneous DME (A9900)	\$316.84	\$280.89

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 §133.10 sets out the procedures for submitting professional medical bills.
3. 28 Texas Administrative Code §134.203 sets out the guidelines for billing and reimbursing professional medical services.
4. 28 Texas Administrative Code §129.5 sets out the procedures for Work Status Reports.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
No Explanations of Benefits were provided.

Issues

1. Did the requestor submit a complete medical bill in accordance with 28 Texas Administrative Code §133.10?
2. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.10 (a) states,

Health care providers, including those providing services for a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 or to political subdivisions with contractual relationships under Labor Code §504.053(b)(2), shall submit medical bills for payment in an electronic format in accordance with §133.500 and §133.501 of this title (relating to Electronic Formats for Electronic Medical Bill Processing and Electronic Medical Bill Processing), unless the health care provider or the billed insurance carrier is exempt from the electronic billing process in accordance with §133.501 of this title.

Review of the submitted documentation finds that a complete medical bill was submitted in accordance with 28 Texas Administrative Code §133.10. Therefore, the disputed services will be reviewed according to applicable rules and fee guidelines.

2. 28 Texas Administrative Code §134.203 (b) states, "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 dispute involves evaluation and management CPT Code 99203. 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 1.42 multiplied by the geographic practice cost index (GPCI) for work of 1.014 is 1.43988. The practice expense (PE) RVU of 1.47 multiplied by the PE GPCI of 1.004 is 1.47588. The malpractice RVU of 0.13 multiplied by the malpractice GPCI of 0.939 is 0.12207. The sum of 3.03783 is multiplied by the Division conversion factor of \$55.75 for a MAR of \$169.36. The requestor is seeking \$127.51 for this service. Therefore, the total allowable for this code is \$127.51.
 - The dispute involves radiology CPT Code 72110. 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 0.31 multiplied by the geographic practice cost index (GPCI) for work of 1.014 is 0.31434. The practice expense (PE) RVU of 1.06 multiplied by the PE GPCI of 1.004 is 1.06424. The malpractice RVU of 0.04 multiplied by the malpractice GPCI of 0.939 is 0.03756. The sum of 1.41614 is multiplied by the Division conversion factor of \$55.75 for a MAR of \$78.95. The requestor is seeking \$73.08 for this service. Therefore, the total allowable for this code is \$73.08.

28 Texas Administrative Code §134.203 (d) states, “The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule.”

- The dispute involves lumbosacral orthosis CPT Code L0625. The fee listed in the DMEPOS fee schedule for this code is \$52.24. 125 percent of this fee is \$65.30. This is the MAR for this code.
- The dispute involves DME CPT Code A9900. This code is defined as “miscellaneous DME supply, accessory, and/or service component of another HCPCS code.” This code has a status of X – Statutory Exclusion, which is defined as follows: “These codes represent an item or service that is not in the statutory definition of ‘physician services’ for fee schedule payment purposes...” Therefore, this code is not payable.

28 Texas Administrative Code §129.5 (i) states, in relevant part, “...a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section ... The amount of reimbursement shall be \$15...” The dispute involves a Work Status Report as defined in 28 Texas Administrative Code §129.5. Therefore, the MAR for this code is \$15.00.

3. The total allowable for the disputed services is \$280.89. The insurance carrier paid \$0.00. Therefore, reimbursement of \$280.89 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 \$280.89.

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 \$280.89 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	Laurie Garnes	_____
Signature	Medical Fee Dispute Resolution Officer	June 17, 2015
		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, 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 MFDR 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.