



# 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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

Shannon Clinic

**Respondent Name**

New Hampshire Insurance Co

**MFDR Tracking Number**

M4-15-3844-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

July 24, 2015

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "We filed an appeal stating we had billed CPT Code 99212-25 correctly with modifier identify office visit as separate evaluation. Our appeal was denied stating our provider non network. We obtained Out of Network approval for these services."

**Amount in Dispute:** \$70.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** The Division received an acknowledgement of receipt of a medical fee dispute on August 4, 2015. 28 Texas Administrative Code 133.307(d)(1) states in pertinent part, "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." As no position statement submitted, this dispute will be based on available information.

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 2, 2015	99212 -25	\$70.00	\$65.53

#### 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 §134.203 sets out the reimbursement guidelines for professional medical services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 236 – This proc or proc/mod combo not compatible w/another proc on same day

### **Issues**

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule that pertains to reimbursement?
3. Is the requestor entitled to additional reimbursement?

### **Findings**

1. The insurance carrier denied disputed services with claim adjustment reason code 236 – "This proc or proc/mod combo not compatible w/another proc on same day." 28 Texas Administrative Code §134.203(b) requires that,

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;

Review of the submitted information finds that the service in dispute was submitted a 99212 -25. The submitted CPT code is defined as "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family." The "25" modifier is defined as, "Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service."

Review of the submitted "Shannon Clinic Note" from April 2, 2015 finds a documentation to support a problem focused exam was conducted prior to the administration of the injection. The insurance carrier's denial reason is not supported as the use of the "25" modifier is supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code 134.203(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: (DWC Conversion Factor / Medicare Conversion Factor) x Participating Amount = TX Fee Mar or  $(56.2/35.7547 \times \$41.69 = \$65.53$ .

3. The maximum allowable reimbursement for the service in dispute is \$65.53. The carrier previously paid \$0.00. The remaining balance is \$65.53. 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 \$65.53.

**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 \$65.53 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

February , 2016  
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.**