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
HCAA Medical Group PA

Respondent Name
American Casualty Co of Reading

MFDR Tracking Number
M4-16-0316-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
October 5, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Bill keeps getting denied stating we have already been paid for this in another service. The patient did have an Initial Evaluation done by Physical Therapy which is a completely separate service and specialty. Only paid us $0.02 for this Physical Therapy bill."

Amount in Dispute: $372.69

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 October 13, 2015. The insurance carrier did not submit a response for consideration in this review. 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." Accordingly, this decision is based on the available information.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 2, 2015	99204, E1805, 99080, 97001, G8984, G8985	$372.69	$124.84

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:
   - 45 – Charges exceed your contracted/legislated fee arrangement
   - W1 – Workers compensation state fee schedule adjustment
   - B12 – Services not documented in patients' medical records
   - 150 – Payer deems the information submitted does not support this level of service
   - BL – This bill is a reconsideration of a previously reviewed bill

Issues

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

Findings

1. The insurance carrier denied the services in dispute for several reasons. Code 99204 was denied as 150 – "Payer deems the information submitted does not support this level of service." Review of the CPT code 99204:

   Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. 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 of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.

The elements of the submitted medical record were reviewed and find;

History

HPI: Status of chronic conditions: 1 condition found. Code requires 3 chronic conditions. Requirements of code not met.

HPI: history of present illness elements: 2 found. Code requires 4 or more. Requirements of code not met

ROS: Review of systems: 4 systems found. Code requires complete or 15. Requirements of code not met

PFSH: Past medical, family, social history areas: None found. Code requires 2 or 3 areas. Requirements of code not met

Examination

Body areas: 1 (each extremity) found: Code requires 8 or more systems. Requirements of code not met.

Medical Decision Making: Minimal. Code requires moderate to high severity. Requirements of code not met.

Time: Not found within documentation.

The carrier's denial is supported as pursuant to 134.203(b) insufficient evidence was found to support the billed code 99204.

The submitted code E1805 was denied with remark code B12 – "Services not documented in patients' medical records." Review of the Supplemental Charting Notes under "Treatment Plan" Treatment and Orders – "Wear cock-up right wrist brace while awake." The carrier's denial is not supported. This service will be reviewed per applicable rules and fee guidelines.

The submitted code 97001 was denied with remark code HA – "The listed treatments include management during the TDI-DW's medical fee guidelines in Rule 28 of the Texas Administrative Code 134.203(A)(5) and (B)(1) require submission of an appropriate functional reporting "G" HCPCS code with a valid impairment modifier. Review of the submitted medical claim finds the claim contained codes G8984 and G8985. The carrier's denial is not supported the service in dispute will be reviewed per applicable 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 for the services in dispute will be calculated as follows:

- The MAR for code 97001 is (DWC Conversion Factor / Medicare Conversion Factor) x Participating amount) or (56.2 / 35.9335) x $79.82 = $124.84

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;

(2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or

(3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.

The submitted medical claim contains the code E1805 –NU, 59. Review of the 2015, Texas DMEPOS 3rd quarter DMEPOS fee schedule finds no listing for E1805 –RR only E1805 -NU. This code is classified as a capped rental and must be rented. Review of the 2015 Texas Medicaid fee schedule for code E1805 on this date of service finds "Not Payable". As 134.203(d)(1) or (2) do not apply the service in dispute is reviewed per Rule 134.203(d)(3).

28 Texas Administrative Code §134.1(f) states,

Fair and reasonable reimbursement shall:

(1) be consistent with the criteria of Labor Code §413.011;

(2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and

(3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

Texas Labor Code §413.011 (d) states,

Fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf.

28 Texas Administrative Code 133.307 (c)(2)(O), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable;" Review of the submitted documentation finds that:

a. The requestor submitted no position statement that asserts that fair and reasonable reimbursement would be 100% of total billed charges.

b. The requestor did not support that reimbursement of $34.00 would be fair and reasonable rate of reimbursement for the service in this dispute.

c. The requestor did not support that payment of the request amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

3. The total allowable for the services in dispute is $124.84. The carrier previously paid $0.00. The requestor is due $124.84.

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 $124.84.

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 $124.84 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		December , 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, 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.