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
ETMC First Physicians

Respondent Name
First Liberty Insurance Corp

MFDR Tracking Number
M4-16-0774-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
November 18, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The above patient date of service 060715 procedure code 97605 has denied as included in another service that was billed on the same claim, per Medicare, CCI Edits and encoder pro there are not conflicts with any codes that have been billed on this claim."

Amount in Dispute: $80.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Dispute MR-16-0774-01 for (claimant) is related to denial of procedure code 97605 as billed in conjunction with 11042 and 11045. This matter is currently undergoing additional review. A complete response with our final determination will be provided as soon as possible."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 7, 2015	97605	$80.00	$65.58

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:
   - MZ02 – Per AA0S guidelines procedure code is included the surgical code when performed at the same encounter. Service is denied as an integral part of procedure code 11045.

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

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

Findings

1. 28 Texas Administrative Code 133.307 (d)(1) states,

   Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.

   (1) Timeliness. 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 carrier acknowledged and responded to Medical Fee Dispute on December 8, 2015. The Division allowed 14 days from this response before proceeding with the Medical Fee Dispute based on the available information.

2. The insurance carrier denied disputed services with claim adjustment reason code MZ02 – "Per AA0S guidelines procedure code is included the surgical code when performed at the same encounter. Service is denied as an integral part of procedure code 11045." 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;

   Review of the submitted information finds insufficient information to support the Carriers denial. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

3. 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 (year of service annual conversion factor).

   The maximum allowable reimbursement will be calculated as follows;

   (DWC Conversion Factor / Medicare Conversion Factor) x Fee Schedule Amount = MAR or

   (56.2 / 35.7547) x $41.72 = $65.58

3. The total allowable for the service in dispute is $65.58. The amount previously paid by the carrier is $0.00. The remaining balance due to the requestor is $65.58. 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 $65.58.

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 $65.58 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

	Peggy Miller	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.