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
Jeff Xinda Zhao

Respondent Name
Liberty Insurance Corp

MFDR Tracking Number
M4-16-1462-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
February 1, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "All claims pertaining to this WC case have been paid but two claims have not been paid and one claim, the surgery, was partially paid."

Amount in Dispute: $2,262.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In accordance with Chapter 28 TAC §10.121, an investigation has been completed on your issue."

Response Submitted by: 2,262.00

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 24, 2015 October 15, 2015 November 12, 2015	20103 -59, 76000 -59 99213, 99080 -73 99213, 99080 -73	$2,262.00	$261.90

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 §133.20 sets out the requirements for medical bill submission by health care providers.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical

services.

4. 28 Texas Administrative Code §134.240 sets out requirements for medical payments and denials.
5. 28 Texas Administrative Code §129.5 sets out the reimbursement guidelines for work status reports.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 150 – X901 – Documentation does not support level of service billed
   - X124 – Payment for this charge is not recommended without medical records.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - W3 – Additional payment made on appeal/reconsideration.
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - 18 – U301 – This item has been reviewed on a previously submitted bill, or is currently in process.
   - X397 – Provider is not within the Liberty Health Care Network (HCN) for this customer.

Issues

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

Findings

1. The services in dispute for date of service June 24, 2015 were denied as X901 – "Documentation does not support level of service billed." The carrier states in letter dated February 9, 2016, "Our denial rationale is as follows: CPT 20103 -59 flags a NCCI Edit when billed with CPT 20525. Modifier 59 is not supported based on the above Medicare/CPT definition, because the exploration was performed on the same body part during the same session as the removal of the foreign body… CPT 76000 -59 flags a NCCI edit when billed with CPT 20525. Modifier 59 is not supported based on the above Medicare/CPT definition, because the fluoroscopy was performed on the same body part during the same session as the removal of the foreign body…" 28 Texas Administrative Code 134.203 (b) states in pertinent part, "(b) 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 2015 CCI edits finds the carrier's denial is supported as the requirements of the -59 modifier (Distinct Procedural Service - Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual) was not met. Therefore the Division finds for codes, 20103 -59, 76000 -59, no additional payment can be recommended.

2. The insurance carrier denied disputed services for date of service October 15, 2015, with claim adjustment reason code X397 – "provider is not within the Liberty Health Care Network (HCN) for this customer." Review of the information found in TX COMP, https://txcomp.tdi.state.tx.us/TXCOMPWeb/notice/ClaimNetMBP.do?isBackAllowed=N&method=view finds no network information for the claimant. Therefore, the carrier's denial is not supported. The services in dispute will be reviewed per applicable rules and fee guidelines.

3. An explanation of benefits was not submitted by either party for date of service November 12, 2015. 28 Texas Administrative Code §134.240(a) states in pertinent part, "An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill." Review of the submitted documentation finds no evidence the requirements of this statute were met. Therefore, the services in dispute for November 12, 2015 will be reviewed per applicable rules and fee guidelines.

   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:

Date of service	Submitted Code	Submitted charge	Allowable	MAR (DWC Conversion Factor / Medicare Conversion Factor) x Participating mount = TX Fee MAR
October 15, 2015	99213	$221.00	$73.77	(56.2/35.7547) x 73.77 = $115.95
October 15, 2015	99080	$15.00	15.00	TAC 129(i) states, Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15.
November 12, 2015	99213	$221.00	$73.77	(56.2/35.7547) x 73.77 = $115.95
November 12, 2015	99080	$15.00	$15.00	$15.00
			Total	$261.90

4. The maximum allowable reimbursement for the services in dispute is $261.90. The carrier paid "$0.00" The remaining balance of $261.90 is due to the requestor.

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 $261.90.

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 $261.90 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.