



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

Texas Bone and Joint Center

Respondent Name

Arch Insurance Co

MFDR Tracking Number

M4-16-1679-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

February 18, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are requesting payment in full at as per the guidelines due to the fact this is a clean claim."

Amount in Dispute: \$718.35

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division receive written acknowledgement of the notice of medical fee dispute on March 15, 2016. 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." No response was received by the Division. Therefore, this dispute will be reviewed per applicable rules and fee guidelines.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 18, 2015	Professional Medical Services	\$718.35	\$121.49

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 §133.210 sets out documentation requirements.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 15 – (150) Payer deems the information submitted does not support this level of service
 - B1 – (B12) Services not documented in patients’ medical records

Issues

1. Is documentation required for services in dispute?
2. Is the reported level of service supported by submitted documentation?
3. What is the applicable rule that pertains to reimbursement?
4. Is reimbursement due?

Findings

1. The carrier denied the services in dispute as B12 – “Services not documented in patients’ medical record.” 28 TAC §133.210 section (d) states:

“Any request by the insurance carrier for additional documentation to process a medical bill shall:

- (1) be in writing;
- (2) be specific to the bill or the bill's related episode of care;
- (3) describe with specificity the clinical and other information to be included in the response;
- (4) be relevant and necessary for the resolution of the bill;
- (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
- (6) indicate the specific reason for which the insurance carrier is requesting the information; and
- (7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation.”

No documentation was found to support that the carrier made an appropriate request for additional documentation with the specificity required by §133.210(d). The division concludes that carrier failed to meet the requirements of 28 TAC 133.210(d). Therefore, the denial for B12 – “Services not documented in patient’s medical record” will not be considered in the dispute.

2. The carrier denied the disputed service Code 99214 as, and 150 – “Payer deems the information submitted does not support this level of service.” 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...

Review of the submitted documentation finds:

- Submitted Code 99214 – *“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 detailed history; A detailed 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, 25 minutes are spent face-to-face with the patient and/or family.”*
- Based on the submitted “Orthopedic Physical Exam” and the E/M Interactive score sheet found at <http://www.novitas-solutions.com/webcenter/portal/MedicareJH/EMScoresheet?>
 - History level – Expanded Problem Focused
 - Exam level – Problem focused
 - Level of Decision Making – Straightforward

Therefore, the Division finds the carrier’s denial is supported. No additional payment can be recommended.

3. The disputed laboratory services are eligible for payment. 28 TAC §134.203(e) states:

“The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows: 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service.” CMS payment policy files identify those clinical laboratory codes which contain a professional component, and those which are considered technical only. The codes in dispute are not identified by CMS as having a possible professional component, for that reason, the MAR is determined solely pursuant to 28 TAC §134.203(e)(1). The maximum allowable reimbursement (MAR) for the services in dispute is 125% of the fee listed for the codes in the 2015 Clinical Diagnostic Laboratory Fee Schedule found on the Centers for Medicare and Medicaid Services website at <http://www.cms.gov>. The disputed medical claim lists the following:

- 80053 – Comprehensive metabolic panel
- 81000 – Urinalysis nonauto w/scope
- 85025 – Complete cbc w/autho diff wbc
- 85610 – Prothrombin time
- 85730 – Thromboplastin time partial

Date of Service	Submitted Code	Amount billed	Allowable	Maximum allowable reimbursement (MAR)
March 18, 2015	80053	\$73.00	\$14.37	\$14.37 x 125% = \$17.96
March 18, 2015	81000	\$22.00	\$4.31	\$4.31 x 125% = \$5.39
March 18, 2015	85025	\$53.00	\$10.58	\$10.58 x 125% = \$13.22
March 18, 2015	85610	\$27.00	\$5.35	\$5.35 x 125% = \$6.69
March 18, 2015	85730	\$41.00	\$8.17	\$8.17 x 125% = \$10.21
			Total	\$53.47

The disputed radiology services are eligible for payment. 28 TAC §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).

Date of Service	Submitted Code	Amount billed	Allowable	Maximum allowable reimbursement (MAR)
March 18, 2015	71020	\$138.35	\$26.22	\$26.22 x 125% = \$32.77
March 18, 2015	93000	\$93.00	\$16.21	\$16.21 x 125% = \$20.25
			Total	\$53.02

The remaining service in dispute is 99080 -73. 28 Texas Administrative Code §129.5 (i) states in pertinent part, 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.

Review of the submitted medical claim finds the requestor submitted this service per applicable rules. Therefore, additional reimbursement is recommended.

4. The total allowable for the services in dispute is \$121.49. 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 \$121.49.

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 in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$121.49 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	April , 2016
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.