



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

James Weiss MD

Respondent Name

TASB Risk Management Fund

MFDR Tracking Number

M4-16-2120-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

March 25, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134. The carrier has not responded or has denied this claim in its entirety following our filing of Request for Reconsideration. Therefore, we are filing for Medical Dispute Resolution at this time per Rule 133.307."

Amount in Dispute: \$469.08

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "No further payment is due as the charges have been reimbursed properly per the fee guidelines, a copy of the EOMB is attached."

Response Submitted by: TASB Management Fund

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: April 24, 2015, 99204, 95886, 95912, A4456, \$469.08, \$147.08

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 reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §134.202 sets out medical fee guidelines for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
• P12 – Workers' compensation jurisdictional fee schedule adjustment

- 97 – Payment is included in the allowance for another service/procedure. This service is global, integral, and/or a component of primary procedure billed.
- W3 – Additional payment made on appeal/reconsideration
- 151 – Payment adjusted because the payer deems the information submitted does not support this many services.

Issues

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

Findings

1. The insurance carrier denied disputed service, 95886 units of service “2” with claim adjustment reason code 151 – “Payment adjusted because the payer deems the information submitted does not support this many services.” 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 that the “Assessment/summary/findings states, “needle evaluation of the Right peroneus longus and the Right gastroc muscles showed slightly increased spontaneous activity.” Review of the applicable Medicare payment policy finds no CCI edits to prevent payment for both procedures. The insurance carrier’s denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

The carrier denied disputed service A4556 as 97 – “Payment is included in the allowance for another service/procedure. The submitted code has a status indicator of “P – Bundled/Excluded Codes” the carriers denial is supported no additional payment is recommended.

2. 28 Texas Administrative Code §134.203 (c)(1) states,

To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

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	Units	Billed Amount	Allowable	(DWC Conversion Factor / Medicare Conversion Factor) x Allowable = MAR	Amount paid
April 24, 2015	99204	1	\$260.90	\$167.63	56.2/35.7547 x \$167.63 = \$263.48 28 Texas Administrative Code §134.202(d) states, In all cases, reimbursement shall be the least of the: (1) MAR amount as established by this rule; (2) health care provider's usual and	\$260.90

					customary charge; The MAR is therefore \$260.90	
April 24, 2015	95886	2	\$289.08	\$92.77	$56.2/35.7547 \times 92.77 \times 2 = \291.63	\$144.54
April 24, 2015	95912	1	\$455.95	\$265.49	$56.2/35.7547 \times \$265.49 = \417.30	\$417.31
				Total	\$969.83	\$822.75

3. The maximum allowable reimbursement for the services in dispute is \$969.83. The carrier previously paid \$822.75. The remaining balance of \$147.08 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 \$147.08.

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 \$147.08 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

June , 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.