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
ULTIMATE PAIN SOLUTIONS

Respondent Name
EASTGUARD INSURANCE COMPANY

MFDR Tracking Number
M4-17-3706-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
August 18, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Provider provided the medically necessary services on the above dates of service. The Hospital billed Gallagher Bassett, but Gallagher Basset only paid $976.53."

Amount in Dispute: $16,118.47

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier properly calculated reimbursement in this case and stands by the reasons for reduction or denial of payment set forth in its Explanation of Benefits . . . Requestor did not submit bills for date of service 1/31/17. . . . Resolution of the extent of injury issue . . . is still pending."

Response Submitted by: Stone Loughlin Swanson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
August 17, 2016 to January 31, 2017	Evaluation & Management, and Work Conditioning Services	$16,118.47	$0.00

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 §133.240 sets out provisions regarding medical payments and denials.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
4. 28 Texas Administrative Code §134.230 sets out guidelines for Return to Work Rehabilitation services.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 00223 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 00084 - CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION.
   - 16 – Claim/service lacks information or has submission billing error(s) which is needed for adjudication.
   - W3 – Request for reconsideration.
   - 193 - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 00072 - THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.
   - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
   - 00086 - DUPLICATE CLAIM/SERVICE
   - 18 – Duplicate claim/service.
   - 00109 - CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted legislated fee arrangement.
   - Z710 - The charge for this procedure exceeds the fee schedule allowance.
   - 59 – Processed based on multiple or concurrent procedure rules.

Issues

1. Are there any outstanding issues related to compensability, extent or liability for the disputed injury?
2. Did the insurance carrier raise new denial reasons or defenses in their response?
3. Is additional payment due for disputed services billed August 17, 2016 and January 31, 2017?
4. What is the recommended payment for disputed services billed August 29, 2016?
5. Is additional payment due for disputed services billed October 5, 2016?
6. Is additional payment due for disputed services billed November 21, 2016?
7. Is additional payment due for code 97545 billed November 28, 2016?
8. Is additional payment due for code 97546 billed November 28, 2016?
9. Is additional payment due for disputed services billed November 30, 2016?
10. Is additional payment due for disputed services billed December 5, 2016?
11. Is additional payment due for disputed services billed January 4, 2017?
12. Is additional payment due for disputed services billed January 11, 2017?
13. Is additional payment due for disputed services billed January 13, 2017?
14. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier states in their response that "Resolution of the extent of injury issue . . . is still pending." Review of the explanations of benefits submitted for review finds no denial reasons listed for any disputed services related to the compensability, extent of injury or liability for the disputed injuries.

   Rule §133.307(d)(2)(B) requires that upon receipt of the request for medical fee dispute resolution, the respondent shall provide any missing information not provided by the requestor and known to the respondent, including:

   > a paper copy of all initial and appeal EOBs related to the dispute, as originally submitted to the health care provider . . . related to the health care in dispute not submitted by the requestor or a statement certifying that the respondent did not receive the health care provider's disputed billing prior to the dispute request.

   Rules §§ 133.240 (e) and (f) list the required elements an explanation of benefits (EOB) must contain, including per §§ 133.240(f)(17)(G) and (H), adjustment reason code(s) conforming to standards described in the rules.

   Review of the EOBs submitted for review finds no denial reasons listed for any disputed services related to the compensability, extent of injury or liability for the disputed injury. Consequently, the division concludes there are no outstanding issues related to the compensability, extent of injury or liability for the disputed services.

2. Review of the insurance carrier's response finds new denial reasons or defenses raised that were not presented to the requestor before the filing of the request for medical fee dispute resolution.

   Rule §133.307(d)(2)(F) requires that:

   > The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

   Pursuant to Rule §133.307(d)(2)(F), the insurance carrier's failure to give notice to the health care provider of specific codes or explanations for reduction or denial of payment as required by Rule §133.240 constitutes grounds for the division to find a waiver of defenses during Medical Fee Dispute Resolution.

   Upon review of the insurance carrier response, the division finds the respondent has raised new denial reasons or defenses of which the carrier failed to give any notice to the health care provider during the bill review process or before the filing of this dispute. Consequently, the division concludes the insurance carrier has waived the right to raise such new denial reasons or defenses during dispute resolution. Any such new defenses or denial reasons will not be considered in this review.

3. **August 17, 2016** and **January 31, 2017**: Rule §133.307(c)(2) requires the requestor to provide records with the request for MFDR in the form and manner prescribed by the division. The request shall include:

   > (J) a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier … and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal

   Although the requestor listed services provided August 17, 2016 and January 31, 2017 on their Form DWC060 *Table of Disputed Services*, the requestor did not provide copies of any medical bills for these services with the dispute request, as required by Rule §133.307(c)(2)(J). Consequently, the request for medical dispute resolution of service dates August 17, 2016 and January 31, 2017 is not supported. Additional payment is not recommended.

4. **August 29, 2016**: The insurance carrier denied disputed evaluation code 99213, August 29, 2016, with reason code 00084 - (16) CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION.

   However, review of the submitted examination report finds sufficient documentation to support evaluation code 99213 for service date August 29, 2016. The insurance carrier's denial reason is not supported. Reimbursement is therefore considered in accordance with applicable division rules and fee guidelines.

   Reimbursement for evaluation services is subject to the *Medical Fee Guideline for Professional Services*, 28 Texas Administrative Code §134.203(c), requiring the maximum allowable reimbursement (MAR) be determined by applying Medicare payment policies with minimal modifications set out in the rule. The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by a conversion factor. The division conversion factor is substituted to calculate the MAR. The conversion factor for 2016 is $56.82.

   Reimbursement is calculated as follows: for procedure code 99213, the Work RVU of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.98843. The practice expense (PE) RVU of 1.01 multiplied by the PE GPCI of 1.006 is 1.01606. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.955 is 0.06685. The sum of 2.07134 is multiplied by the DWC conversion factor of $56.82 for a MAR of $117.69.

5. **October 5, 2016**: The insurance carrier denied disputed evaluation code 99213, October 5, 2016, with reason code 00084 - (16) CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION.

   The EOBS do not describe or explain what information was lacking or what submission billing errors were present on the claim; however, review of the submitted information finds no documentation to support evaluation code 99213 for October 5, 2016. The requestor did not submit reports or exam documentation for October 5, 2016 in accordance with Medicare policies as required by Rule §133.307(c)(2)(K). The insurance carrier's denial reason is supported. Payment is not recommended.

6. **November 21, 2016**: The insurance carrier denied codes 97545 and 97546, November 21, 2016, with denial reason code 00072 - (4) THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.

   The disputed services are work conditioning services subject to the *Medical Fee Guideline for Return to Work Rehabilitation Programs*, 28 Texas Administrative Code §134.230(2)(A) which requires that:

   > The first two hours of each session shall be billed and reimbursed as one unit, using CPT code 97545 with modifier "WC." Each additional hour shall be billed using CPT code 97546 with modifier "WC."

   Review of the submitted medical bills finds the required modifier "WC" to be absent from the bill. The insurance carrier's denial reason is supported. Payment is not recommended.

7. **November 28, 2016 (code 97545)**: The insurance carrier denied code 97545, November 28, 2016, with denial reason code 00072 – (4) THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.

   The disputed services are work conditioning services subject to the *Medical Fee Guideline for Return to Work Rehabilitation Programs*, 28 Texas Administrative Code §134.230(2)(A) which requires that:

   > The first two hours of each session shall be billed and reimbursed as one unit, using CPT code 97545 with modifier "WC." Each additional hour shall be billed using CPT code 97546 with modifier "WC."

   Review of the submitted medical bills finds the required modifier "WC" to be absent from the bill. The insurance carrier's denial reason is supported. Payment is not recommended.

8. **November 28, 2016 (code 97546)**: The carrier denied code 97546-WC, November 28, 2016, with reason code 00084 - (16) CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION.

   Review of the submitted medical bill finds that, although the provider billed the service with modifier WC, as required by Rule §134.230(2)(A), the provider billed this code with 6 units — indicating 6 (additional) hours performed *beyond* the initial 2 hours, for a total of 8 hours billed. However, the submitted medical records document only 4 hours total of work conditioning performed for this date. The units on the medical bill are inconsistent with the medical records. The insurance carrier's denial reason is supported. Payment is not recommended.

9. **November 30, 2016**: The insurance carrier denied codes 97545-WC and 97546-WC, November 30, 2016, with denial code 00084 - (16) CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION; and 00109 – (45) CHARGE EXCEEDS FEE SCHEDULE/ MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.

   The requestor's *Table of Disputed Services* indicates the carrier paid $172.80 for code 97545-WC without paying code 97546-WC — on the other hand, the EOB indicates the carrier paid $172.80 for code 97546-WC for that date, *without* paying code 97545-WC. In either case, the medical bill lists a total of 8 hours work conditioning performed on that date (2 initial hours included in code 97545-WC plus 6 hours billed under code 97546-WC).

   However, the medical record documents only *4 hours* of work conditioning total actually performed on that date. Rules §§ 134.230(1)(A) and (2)(A), allow 80% of $36 per hour of work conditioning for a non-CARF accredited program, or $28.80 per hour. The total payment for the 4 hours documented is $115.20. The carrier paid $172.80. Additional payment is not recommended.

10. **December 5, 2016**: The carrier reduced payment for 97545-WC and 97546-WC, December 5, 2016, with codes 00084 - (16) CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION; and 00109 - (45) CHARGE EXCEEDS FEE SCHEDULE/ MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.

    Review of the submitted EOBs finds the carrier paid $57.60 for code 97545-WC and $172.80 for code 97546-WC. The medical bill lists a total of 8 hours of work conditioning performed on that date (2 initial hours included in code 97545-WC plus 6 hours billed under code 97546-WC). However, the medical record documents only 4 hours of work conditioning total performed on that date. Per Rule §§ 134.230(1)(A) and (2)(A), the guideline allows 80% of $36 per hour of work conditioning for a non-CARF accredited program, or $28.80 per hour. The total payment for the 4 hours documented is $115.20. The carrier paid a total of $230.40. Additional payment is not recommended.

11. **January 4, 2017:** The requestor lists only code 97545 in dispute for January 4, 2017on the **Form DWC060** *Table of Disputed Services*. Review of the medical bill finds 1 unit (initial 2 hours of work conditioning) for code 97545-WC billed for this date. The medical record documents 4 hours work conditioning performed on that day. The carrier paid $57.60 for this service as billed. The carrier's payment is in accordance with Rules §§ 134.230(1)(A) and (2)(A), which allow 80% of $36 per hour of work conditioning (for a non-CARF accredited program), or $28.80 per hour, for a total of $57.60 for the initial two hours. Additional payment is not recommended.

12. **January 11, 2017:** Rule §133.307(c)(2) requires the requestor to provide records with the request for MFDR in the form and manner prescribed by the division. The request shall include:

    (K) a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider … or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB

    The requestor lists only code 97545 for January 11, 2017 in dispute on the **Form DWC060** *Table of Disputed Services*; however, the requestor did not provide complete copies of EOBs for these services with their dispute request, as required by Rule §133.307(c)(2)(J). Furthermore, the medical record for this date documents *no* hours of work conditioning performed to support the services as billed. Based on review of the submitted documentation, the request for additional payment for January 11, 2017 is not supported.

13. **January 13, 2017:** The requestor lists only code 97545 in dispute for January 13, 2017on their **Form DWC060** *Table of Disputed Services*. Review of the medical bill finds 1 unit (initial 2 hours of work conditioning) for code 97545-WC billed on this date. However, the medical record does not document or support any work conditioning performed on that day. Nevertheless, the submitted EOBs support the carrier paid $57.60 for this service as billed. The carrier's payment is in accordance with Rules §§ 134.230(1)(A) and (2)(A), which allow 80% of $36 per hour of work conditioning (for a non-CARF accredited program), or $28.80 per hour, for a total of $57.60 for the initial two hours. Additional payment is not recommended.

14. Based on the above findings, the health care provider has supported reimbursement of:

    $117.69 for August 29, 2016
    $115.20 for November 30, 2016
    $115.20 for December 5, 2016
    $57.60 for January 4, 2017

    For a total supported reimbursement of $405.69.

    Based on the findings above, the insurance carrier has paid:

    $172.80 for November 30, 2016
    $230.40 for December 5, 2016
    $57.60 for January 4, 2017
    $57.60 for January 13, 2017

    The insurance payments for the services addressed in the findings above total $518.40

    The division notes additionally that the submitted EOBs support the carrier made other payments that are not addressed in the above findings.

    As detailed above, the total recommended reimbursement for the disputed services is $405.69.
    The carrier has made payments totaling $518.40 in reference to the services addressed above.
    The division concludes that no additional payment is due.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	September 7, 2018
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 Rule §133.307.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.