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
UT Southwestern MSP

Respondent Name
National Fire Insurance Co of Hartford

MFDR Tracking Number
M4-17-3865-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
August 30, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has continued to deny the services stating the procedures were not probably[sic] documented. The pathology report clearly shows there were 3 nerve specimens submitted."

Amount in Dispute: $10,194.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "At this time, Carrier maintains any and all denials as represented in the attached EOR."

Response Submitted by: Brian J. Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 30, 2016	64784, 64784, 64787, 64787	$10,194.00	$2,506.94

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 services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 112 – Service not furnished directly to the patient and/or not documented
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 59 – Processed based on multiple or concurrent procedure rules

Issues

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

Findings

1. The requestor is seeking reimbursement in the amount of $10,194.00 for Codes 64787 – "Implantation of nerve end into bone or muscle" and 64784 – "Excision of neuroma; major peripheral nerve, except sciatic" performed in an outpatient setting on August 30, 2016.

   The insurance carrier denied disputed services with claim adjustment reason code 112 – "Service not furnished directly to the patient and/or not documented."

   Review of the "Op Note" Date of Service: 08/30/16 finds the following:

   > "We went along the iliacs inside, but could not find evidence obviously this was a nerve other than some areas which were yellow strings, which, we sent as specimens and buried in the musculature... In total, we were able to identify 3 structures that were in the directions of the nerves but looked more like elongated fatty areas which could be compatible more with dead nerves, but we sent these as specimens to check if there is an architecture of nerves."

   Review of the "Biopsy or Surgical Specimen" finds the following:

   A. Right groin tissue or nerve #1, biopsy

   B. Right groin tissue or nerve #2, biopsy

   C. Right groin tissue or nerve #3, biopsy

   Based on this review, the Division finds the carrier's denial is not supported. The services in dispute will be reviewed per applicable fee guideline.

2. 28 Texas Administrative Code 134.203 (c) states in pertinent part,

   > 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). For Surgery when performed in a facility setting, the established conversion factor to be applied is (date of service yearly conversion factor).

   The maximum allowable reimbursement is calculated below.

Submitted Code	Medicare Allowable	Multiple Procedure Discount at 50%	MAR = DWC Conversion Factor/Medicare Conversion Factor x Allowable
64784	$746.71	$373.36	72.18/35.8887 x $373.36 = $750.91
64784	$746.71	$373.36	72.18/35.8887 x $373.36 = $750.91
64787	$249.88	Not applicable	72.18/35.8887 x $249.88 = $502.56
64787	$249.88	Not applicable	72.18/35.8887 x $249.88 = $502.56
		Total	$2,506.94

3. The allowable for the services in dispute is $2,506.94. The carrier paid $0.00. The balance of $2,506.94 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 $2,506.94.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $2,506.94, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

Signature	Peggy Miller Medical Fee Dispute Resolution Officer	September 21, 2017 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, effective May 31, 2012, *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. **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.