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**
Mark Henry MD

**Respondent Name**
United Airlines Inc

**MFDR Tracking Number**
M4-18-0915-01

**Carrier's Austin Representative**
Box Number 48

**MFDR Date Received**
December 4, 2017

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The attached medical records adequately support each of the services provided and is sufficient to warrant payment as set forth by the aforementioned section of the Texas Administrative Code."

**Amount in Dispute:** $2,518.88

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of review.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| January 20, 2017 | 20680 | $2,518.88 | $2,044.82 |

## *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 the requirements for medical documentation
3. 28 Texas Administrative Code §134.203 sets out the guideline for professional services fee guidelines.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - B12 - Services not documented in patients' medical records
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
   - 252 – An attachment/other documentation is required to adjudicate this claim/service

**Issues**

1. Did United Airlines Inc respond to the medical fee dispute?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. What is the rule applicable to reimbursement?
4. Is the requestor entitled to additional reimbursement?

**Findings**

1. The Austin carrier representative for United Airlines Inc is Gallagher Bassett Services. Gallagher Bassett Services acknowledged receipt of the copy of this medical fee dispute on December 11, 2017.

   28 Texas Administrative Code §133.307 states, in relevant part:

   > (d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
   > (1) Timeliness. 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** [emphasis added]. 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.

   Review of the documentation finds that no response has been received on behalf of United Airlines Inc from Gallagher Bassett Services to date. The division concludes that United Airlines Inc failed to respond within the timeframe required by §133.307(d)(1). For that reason the division will base its decision on the information available.

2. The insurance carrier denied disputed services with claim adjustment reason code B12 – "Services not documented in patients' medical record." 28 Texas Administrative Code §133.210 (a) states,

   > Medical documentation includes all medical reports and records, such as evaluation reports, narrative reports, assessment reports, progress report/notes, clinical notes, hospital records and diagnostic test results.

   Review of the submitted "Clinical Note" dated January 20, 2017, page 4, found;

   > "Pin Removal: A pin was removed, Number of deep pins: 2"

   Review of the submitted medical bill contained a claim line with Code 20680 – "Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate.)"

   28 Texas Administrative Code §134.203 (b) states in pertinent part,

   > 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;

   Based on the above, the insurance carrier's denial reason is not supported as the description of the code submitted on the medical bill was found within the submitted medical record. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

3. 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.)

The place of service on the submitted medical claim was (11) home. The maximum allowable reimbursement calculation is as follows:

- Procedure code 20680, January 20, 2017. For this code, the DWC Conversion factor of 57.5/35.887 (Medicare Conversion Factor) is multiplied by the Medicare Fee schedule amount of $638.14 = $1,022.41 x 2 units = $2,044.82.

4. The total allowable reimbursement for the services in dispute is $2,044.82. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $2,044.82. 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 $2,044.82.

## *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 $2,044.82, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

**Authorized Signature**

| | | |
|---|---|---|
| | | February 1, 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, 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**.