TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Orthotexas Physicians and Surgeons

Respondent Name
Amerisure Mutual Insurance Co

MFDR Tracking Number
M4-18-4144-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
June 29, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…CPT 20605 & J1030 denied for no auth however per Rule 134.600 of the DWC Labor Code a steroid injection is not listed as a non-emergency service requiring pre-authorization. …CPT 20611 & J0702 denied for no auth however per Rule 134.600 of the DWC Labor Code a steroid injection is not listed as a non-emergency service requiring pre-authorization."

Amount in Dispute: $571.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon review of the MFDR Request we find that this claim is in the Texas First Health Network and as such is not subject to the Medical Fee Dispute Resolution process. However, we will respectfully re-review the bills in question for reconsideration."

Response Submitted by: Amerisure

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 2, 2017 November 29, 2017	20611, J0702 20605, J1030	$272.60	$264.14

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 §133.20 sets out the requirements for claim submission for workers compensation claims.
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:
   - 197 – Payment denied/reduced for absence of precertification/preauthorization

Issues

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

Findings

1. The respondent states, "Upon review of the MFDR Request we find that this claim is in the Texas First Health Network…"

   Although Texas First Health Network. is listed as a certified network on the Division's webpage, the carrier did not provide convincing evidence that the injured employee is enrolled in this network.

   The Division concludes that the carrier failed to support its position statement. Therefore, the service in dispute will be reviewed per applicable Division fee guideline.

2. The requestor is seeking $272.60 for professional medical services provided in the physician's office on November 2, 2017 and November 29, 2017 in the amount of $272.60. The insurance carrier denied the disputed services with claim adjustment reason code, 197 – "Payment denied/reduced for absence of precertification/preauthorization."

   Review of 28 TAC 134.600 (p) found no prior authorization requirement for professional medical services performed in a physician's office. The carrier's denial is not supported.

3. The services in dispute are for professional medical services. The applicable rule is 28 Texas Administrative Code §134.203 (c)(1) which 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).

   For codes 20605 and 20611 the maximum allowable reimbursement is calculated as follows:

   (DWC Conversion Factor/Medicare Conversion Factor) x Allowable = TX Fee MAR

   Code 20605 (57.5/35.8887) x $49.07 = $78.62

   Code 20611 (58/35/8887) x $88.47 = $141.74

   Total $220.36

   28 Texas Administrative Code §134.203 (d) The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

   (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;

   (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS;

   For code J0702 the following the MAR is calculated as (Fee schedule amount x 125%). Review of the January 2017 Medicaid Pricing File found at http://public.tmhp.com/FeeSchedules/Default.aspx, finds an allowable of $5.51 for Code J0702 and $6.00 for Code J1030. The MAR is ($5.51 x 125% x 2) = $13.78. ($6.00 x 125% x 4) = $30.00.

   The total allowable for the services in dispute is $264.14. 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 $264.14.

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 involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $264.14 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		December 20, 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 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.