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
NUEVA VIDA BEHAVIORAL HEALTH A

Respondent Name
XL SPECIALTY INSURANCE CO

MFDR Tracking Number
M4-20-2787-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 29, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Healthcare provider in dispute did not provide a position statement.

Amount in Dispute: $170.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 28, 2020	Code 96158	$93.50	$93.50
	Code 96159	$76.50	$76.50

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 TAC §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes: No explanation of benefits provided

Issues

1. What is the MAR reimbursement for CPT Code 96158 and 96159?
2. Is the requestor entitled to reimbursement?

Findings

1. The fee guideline for disputed services is found at 28 TAC§134.203.
   Per 28 TAC §134.203(c)(1)(2), "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 $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.
   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the DWC had been using this MEI annual percentage adjustment: The 2006 DWC conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) DWC conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

CPT CODE – 96158

- The 2020 DWC conversion factor for disputed service 96158 is 60.32. The Medicare Conversion Factor is 36.0896
- Review of Box 32 on the CMS-1500 the services were rendered in San Antonio, Texas; therefore, the Medicare facility is "Rest of Texas"
- The Medicare participating amount for code 96158 at this locality is $66.90.
- Using the above formula, the MAR is $111.82/unit. The requestor billed for 1 unit; therefore $111.82 x 1 = $111.82. The lesser of the MAR and the sought amount is $93.50. The requestor seeks $93.50; therefore $93.50 is recommended. The respondent paid $0.00. The DWC finds, the requestor is due reimbursement of $93.50 for Code 96158.

CPT CODE – 96159

- The 2020 conversion factor for 96159 is 60.32. The Medicare Conversion Factor is 36.0896
- Review of Box 32 on the CMS-1500 the services were rendered in San Antonio, Texas. Therefore, the Medicare locality is "Rest of Texas"
- The Medicare participating amount for code 96159 at this locality is $23.33
- Using the above formula, the MAR is $38.99/unit. The requestor billed for 2 units, therefore, $38.99 x 2 = $77.99. The lesser of the MAR and the sought amount is $76.50, therefore, this amount is recommended. The requestor seeks $76.50 for 2 units. The respondent paid $0.00. The DWC finds the requestor is due reimbursement of $76.50 for Code 96159.

3. Review of the submitted documentation finds that the requestor is entitled to a total reimbursement amount of $170.00.

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 $170.00.

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 $170.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

[redacted]	[redacted]	October 14, 2020
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.