TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Alison Walls Phd

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-22-0451-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
November 2, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 12, 2021	90791	$309.45	$0.00
March 12, 2021	96130	$206.31	$0.00
March 12, 2021	96131	$2029.82	$1107.89
March 12, 2021	96136	$78.75	$0.00
March 12, 2021	96137	$0.00	$0.00
	Total	$1107.89	$1107.89

Requestor's Position

The carrier has not paid this claim in accordance and compliance with TDI-DWC 133 and 134.

Amount in Dispute: $1,107.89

Respondent's Position

Texas Mutual has reviewed the DWC 60 submitted by Alison Walls Phd. Review of the claim file and bill history it is confirmed Texas Mutual issued payment to the provider. Our position is that no payment is due.

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.203 sets out the fee guidelines of professional medical claims.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- P12 – Workers' Compensation jurisdictional fee schedule adjustment
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- 192 – The provider has been reimbursed the additional PHSAA amount
- 629 – The medically unlike edits (MUE) from CMS has been applied to this procedure code
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline
- 131 – Claim specific negotiated discount
- 144 – Incentive adjustment e.g. preferred product/service
- DC3 – Additional reimbursement allowed after reconsideration

Issues

1. Is the insurance carrier's reduction based on medically unlikely edits supported?

2. What rule is applicable to reimbursement?

3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of professional medical services rendered in March 2021. One of the reduction reasons stated on the explanation of benefits was CMS medically unlikely edits.

   CMS MUE's were implemented by Medicare in 2007. MUE's set a maximum number of units for a specific service that a provider would report under most circumstances for a single patient on a single date of service. Medicare developed MUE edits to detect potentially medically unnecessary services.

   Although the DWC adopts Medicare payment policies by reference in applicable Rule

§134.203, paragraph (a)(7) of that rule states that specific provisions contained in the Division of Workers' Compensation rules shall take precedence over any conflicting provision adopted the Medicare program.

The Medicare MUE payment policy is in direct conflict with Texas Labor Code §413.014 which requires that all determinations of medical necessity shall be made prospectively or retrospective through utilization review; and with Rule §134.600 which sets out the procedures for preauthorization and retrospective review of professional services such as those in dispute here. The DWC concludes that Labor Code §413.014 and 28 TAC §134.600 take precedence over Medicare MUE's; therefore, the respondent's reduction reason is not supported.

An additional reduction reason was a negotiated claim amount. Insufficient evidence was found to support a negotiated discount. The services in dispute will be reviewed per applicable fee guidelines.

2. DWC Rule §134.203 (c) (1) states in pertinent part the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   The calculation of the MAR is based on the DWC Conversion Factor / Medicare Conversion Factor multiplied by the Medicare allowable for the disputed services is as follows:

   - Code 90791 - 61.17/34.8931 x $176.83 x 1 unit = $310.00
   - Code 96130 - 61.17/34.8931 x $117.89 x 1 unit = $206.67
   - Code 96131 - 61.17/34.8931 x $89.22 x 13 units = $2,033.31
   - Code 96136 - 61.17/34.8931 x $45.00 x 1 unit = $78.89
   - Code 96137 - 61.17/34.8931 x $70.91 x 7 units = $496.38

3. The total allowed amount is $3,125.25. The insurance carrier provided evidence of a payment in the amounts of $1,516.34 and $495.63 for a total of $2,011.97. The requestor is seeking $1107.89. This amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. {It is ordered that Texas Mutual Insurance

Co must remit to Allison Walls $1107.89 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.}

Authorized Signature

		March 18, 2022
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.