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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALAMO CITY MEDICAL GROUP
PO BOX 1810
SAN ANTONIO TX 78296

Respondent Name
EMPLOYERS PREFERRED INS CO

Carrier's Austin Representative Box
Box Number 04

MFDR Tracking Number
M4-13-0591-01

MFDR Date Received
OCTOBER 30, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary.

Amount in Dispute: $336.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier or its agent did not respond to the request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 9, 2012	CPT Code 12001 – Repair, superficial wound(s)	$204.00	$140.85
May 9, 2012	CPT Code 90471 Immunization	$32.00	$32.00
May 9, 2012	CPT Code 99201-25 – Office visit, new patient	$60.00	$0.00
May 9, 2012	CPT Code 99080-73 – Work Status Report	$15.00	$15.00
May 9, 2012	CPT Code 90718 – Td vaccine > 7 im	$25.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 a medical fee dispute.

2. 28 Texas Administrative Code §134.203 sets out reimbursement for reimbursement of professional services.
3. 28 Texas Administrative Code §129.5 sets out reimbursement for reimbursement of the Work Status Report.
4. 28 Texas Administrative Code §134.1 entitled Medical Reimbursement.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - 1 – This charge denied because an invalid code was submitted on the bill or the bill has missing or invalid required information.
    - 2, 3 – NDC codes are not permitted on professional bills. Resubmit the entire bill with a valid CPT or HCPC for this service.
    - 3, 4 – Recommendation of payment has been based on this procedure code, 14362011103, which best describes services rendered.
    - 1, *, (D) – This item was previously submitted and reviewed with notification of decision issued to payor, provider (duplicate invoice).
    - 1 – (18) Duplicate claim/service.
    - 2 – (125) Submission/billing error(s).

Issues

1. Did the insurance carrier reimburse according to the fee guideline?
2. Is the requestor entitled to reimbursement?

Findings

1. According to the submitted EOBs the respondent denied the services in dispute using denial codes 1 – "This charge denied because an invalid code was submitted on the bill or the bill has missing or invalid required information"; 2 – "NDC codes are not permitted on professional bills. Resubmit the entire bill with a valid CPT or HCPC for this service"; 3, 4 – "Recommendation of payment has been based on this procedure code, 14362011103, which best describes services rendered"; 1, *, (D) – This item was previous submitted and reviewed with notification of decision issued to payor"; 1 – "(18) Duplicate claim/service"; and 2 – "(125) Submission/billing error(s)." In accordance with 28 Texas Administrative Code §134.203(b)(1) Texas workers' compensation system participants shall apply Medicare payment policies, including its coding; billing; correct coding initiatives edits; modifiers… Review of the CPT codes billed by the requestor finds all codes were valid on the date the services were performed. The respondent did not submit any documentation and has failed to support their denial. Therefore reimbursement is as follows:
    - CPT Code 12001 – (54.96 ÷ 34.0376) x 87.39 = $140.85
    - CPT Code 99201-25 – According to Medicare payment policies modifier -25 is defined as a significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service. Review of the documentation submitted by the request finds that the injured worker sought medical treatment for the right ring finger; therefore, no separately identifiable evaluation and management service was found. Therefore, reimbursement is not recommended.
    - CPT Code 90471 - (54.96 ÷ 34.0376) x 22.51 = $32.00
    - CPT Code 90718 – According to Medicare, this code was an active code until it was deleted on December 31, 2012. Therefore the respondent has not supported their denials. In accordance with the Medicare payment policies this CPT code is not priced by Medicare; therefore, per 28 Texas Administrative Code §134.1(e)(3) states that in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section. Subsection (f) states that fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available. The requestor has not submitted documentation to support fair and reasonable, as such, reimbursement is not recommended.
    - CPT Code 99080-73 – In accordance with 28 Texas Administrative Code §129.5(d)(1), the doctor shall file the Work Status Report after the initial examination of the employee, regardless of the employee's work status. Review of the DWC-73 finds the service was rendered as billed. Therefore, reimbursement is due.

2. Because the requestor has supported some of the services in dispute, reimbursement in the amount of $187.85 is due

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $.187.85.

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 $187.85 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		March 12, 2014
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, 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 MDR 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).

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