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

DR PETER G FOOX
PO BOX 8795
TYLER TX 75711

Respondent Name
ACE AMERICAN INSURANCE CO

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-13-1349-01

MFDR Date Received
JANUARY 29, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I was selected as the 'treating Dr.' & under DWC rules I have an obligation to 'see' the patient & get paid for my services. How can I be expected to become the Treating Doctor - & not see the patient or see the patient & not get paid for it? In addition the adjuster – Melissa Nancy said that they would pay for the visit & also for 9/21/12, yet we are denied for both – we need honesty in adjusters to be above & beyond reproach. In addition they tried to deny having received my Bills as an excuse not to pay But we had proof – The lengths they go to deny!"

Amount in Dispute: $480.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary February 20, 2013: "We have requested our third-party repricer to review the bill for the date of service in question to confirm that we have paid the correct recommended allowance. An addendum will be filed when the review is complete, and payment will be issued if any additional allowance is recommended."

Respondent's Supplemental Position Summary March 4, 2013: "ESIS maintains its denial of services billed for 8/22/2012-09/21/2012 as it is our position that the treatment provided exceeded ODG guidelines and therefore required preauthorization per rule 134.600. Attached is the PLN-11 and peer review to support our position, along with documentation that the claims representative did notify the provider of the issues prior to services rendered."

Responses Submitted by: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 22, 2012	CPT Code 99204 – Office Visit New Patient	$285.00	$246.58
	CPT Code 97750-59 – Physical Performance Evaluation	$57.00	$49.53
	CPT Code 99080-73 – Work Status Report	$15.00	$15.00
September 21, 2012	CPT Code 99213 – Office Visit	$123.00	$107.86

TOTAL		$480.00	$418.97

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 effective March 1, 2008, sets the reimbursement guidelines for the disputes service.
3. 28 Texas Administrative Code §133.240, effective July 1, 2012, requires a reason code and explanation for reduction in payment.
4. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
5. 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.

Issues

1. Did the respondent process the medical bills in dispute in accordance with 28 Texas Administrative Code §133.240?
2. Did the respondent submit the response in accordance with 28 Texas Administrative Code §133.307?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.240(f)(17)(G) and (H) states "health care service information for each billed health care service, to include: (G) adjustment reason code that conforms to the standards described in §133.500 and §133.501 of this title if total amount paid does not equal total amount charged; and (H) explanation of the reason for reduction/denial if the adjustment reason code was included under subparagraph (G) of this paragraph and if applicable." Review of the submitted explanation of benefits finds that the respondent did not list any denial reason codes to determine the basis for the reduction in payment; therefore, the respondent did not process the disputed bills in accordance with28 Texas Administrative Code §133.240.
2. The respondent states in the position summary that "it is our position that the treatment provided exceeded ODG guidelines and therefore required preauthorization per rule 134.600. Attached is the PLN-11 and peer review to support our position, along with documentation that the claims representative did notify the provider of the issues prior to services rendered."

   28 Texas Administrative Code §133.307(d)(F) states "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section."

   The Division finds that the respondent raises issues in the position summary that were not presented to the requestor prior to the date the request for MFDR was filed with the division. A review of the submitted explanation of benefits does not list any denial reasons to support the issues raised in the position summary; therefore, the response was not submitted in accordance with 28 Texas Administrative Code §133.307. As a result, the disputed services will be reviewed per applicable Division rules and guidelines.
3. Per 28 Texas Administrative Code §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 Division had been using this MEI annual percentage adjustment: The 2006 Division 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) Division 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).

The 2012 DWC conversion factor for this service is 54.86.

The Medicare Conversion Factor is 34.0376

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75702, which is located in Smith County.

Using the above formula, the Division finds the following:

Code	Calculation for Locality	Maximum Allowable
99204	(54.86/34.0376) X $152.99 for 1 Unit	$246.58
97750	(54.86/34.0376) x $30.73 for 1 Unit	$49.53
99213	(54.86/34.0376) x $66.92 for 1 Unit	$107.86
		$403.97

28 Texas Administrative Code §134.204 (l) states "The following shall apply to Work Status Reports. When billing for a Work Status Report that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section, refer to §129.5 of this title (relating to Work Status Reports)."

28 Texas Administrative Code §129.5(i)(1) states "Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15. A doctor shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section." The requestor billed CPT code 99080-73 for the work status report, as a result reimbursement of $15.00 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 $418.97.

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 $418.97 plus applicable accrued interest per 28 Texas Administrative Code §134.130 , due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	02/19/2014 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).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.