



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

MONZER YAZJI, MD

Respondent Name

EDCOUCH ELSA INDEPENDENT SCHOOL DISTRICT

MFDR Tracking Number

M4-17-3598-01

Carrier's Austin Representative

Box Number 29

MFDR Date Received

August 9, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "payment has NOT been received for this service."

Amount in Dispute: \$870.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Attached please find Evidence of Payment for the fees"

Response Submitted by: Dean G. Pappas, PLLC

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Dispute Amount, Amount Due. Row 1: June 16, 2016 to February 6, 2017; Physical Therapy Services with Work Status Reports; \$870.00; \$6.97

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 §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §134.204 sets out fee guidelines for Workers' Compensation specific services.
4. 28 Texas Administrative Code §129.5 sets out guidelines for the filing of and payment for work status reports.
5. The insurance carrier issued payments with explanations of benefits dated after the filing of the request for medical fee dispute resolution.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes: P12 - Workers' compensation jurisdictional fee schedule adjustment, B13 - Previously paid.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the reimbursement for the work status reports billed under code 99080-73?
3. What is the recommended payment for the therapy services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes: B13 – “Previously paid. Payment for this claim/service may have been provided in a previous payment” and P12 – “Workers' compensation jurisdictional fee schedule adjustment.”

Rule §133.307(d)(2)(B) requires that the respondent shall provide any missing information not provided by the requestor and known to the respondent, including:

a paper copy of all initial and appeal EOBs related to the dispute, as originally submitted to the health care provider in accordance with this chapter, related to the health care in dispute not submitted by the requestor

Neither the requestor nor the respondent provided copies of any EOBs showing previous payment. None of the submitted information supported prior payment. The division finds reason code B13 is not supported.

The respondent provided documentation to support that payments for these services were issued by the insurance carrier on August 23, 2017 — *after* the request for medical fee dispute resolution was filed with the division, on August 9, 2017.

Rule §133.307(d)(2)(F) requires that:

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.

The respondent is limited at Medical Fee Dispute Resolution to arguing those denial reasons the carrier has presented to the requestor prior to the request for MFDR. Failure to raise specific denial reasons during the medical bill review process or reconsideration are grounds for the division to find a waiver of defenses at MFDR. Any newly raised denial reasons or defenses presented after the filing of the MFDR request shall not be considered in this review.

As the submitted explanations of benefits assert that the disputed services were paid according to the workers' compensation jurisdictional fee schedule, the disputed services will be reviewed for payment according to applicable division rules and fee guidelines.

2. This dispute regards, in part, payment for work status reports issued November 7, 2016 and February 6, 2017, billed under procedure code 99080-73. Reimbursement for these reports is subject to the provisions of 28 Texas Administrative Code §129.5(i), which requires that “The amount of reimbursement shall be \$15.” This amount is recommended as payment for both reports, for a total of \$30.00.
3. This dispute regards payment of rehabilitation and therapy services with reimbursement subject to the division's *Medical Fee Guideline for Professional Services*, at 28 Texas Administrative Code §134.203, which requires that to determine the maximum allowable reimbursement (MAR), system participants shall apply Medicare payment policies with minimal modifications as set forth in the rule.

Rule §134.203(c) specifies that:

- (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. . . .
- (2) The conversion factors listed in paragraph (1) . . . 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. . . .

The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by a conversion factor. The MAR is calculated by substituting the division's conversion factor(s).

The applicable division conversion factor for services performed in calendar year 2016 is \$56.82.

The applicable division conversion factor for services performed in calendar year 2017 is \$57.50.

Reimbursement is calculated as follows:

- For procedure code G0283, service date June 16, 2016, the relative value (RVU) for work of 0.18 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.18. The practice expense (PE) RVU of 0.2 multiplied by the PE GPCI of 0.92 is 0.184. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.822 is 0.00822. The sum of 0.37222 is multiplied by the division's 2016 conversion factor of \$56.82 for a MAR of \$21.15. Per Medicare policy, when more than one unit of designated therapy services is billed, full payment is made for the first unit of the code with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is \$15.92.
 - For procedure code 97110, service date June 16, 2016, the relative value (RVU) for work of 0.45 multiplied by the Work GPCI of 1 is 0.45. The PE RVU of 0.44 multiplied by the PE GPCI of 0.92 is 0.4048. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.822 is 0.01644. The sum of 0.87124 is multiplied by the division's 2016 conversion factor of \$56.82 for a MAR of \$49.50. Per Medicare policy, when more than one unit of designated therapy services is billed, full payment is made for the first unit of the code with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This code has the highest PE for this date. The first unit is paid at \$49.50. The PE reduced rate is \$38.00 at 2 units is \$76.00. The total is \$125.50.
 - For procedure code 97124, service date June 16, 2016, the relative value (RVU) for work of 0.35 multiplied by the Work GPCI of 1 is 0.35. The PE RVU of 0.38 multiplied by the PE GPCI of 0.92 is 0.3496. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.822 is 0.00822. The sum of 0.70782 is multiplied by the division's 2016 conversion factor of \$56.82 for a MAR of \$40.22. Per Medicare policy, when more than one unit of designated therapy services is billed, full payment is made for the first unit of the code with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is \$30.29.
 - For procedure code 99213, service date November 7, 2016, the relative value (RVU) for work of 0.97 multiplied by the Work GPCI of 1 is 0.97. The PE RVU of 1.01 multiplied by the PE GPCI of 0.92 is 0.9292. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.822 is 0.05754. The sum of 1.95674 is multiplied by the division's 2016 conversion factor of \$56.82 for a MAR of \$111.18.
 - For procedure code 99213, February 6, 2017, the relative value (RVU) for work of 0.97 multiplied by the Work GPCI of 1 is 0.97. The PE RVU of 1.02 multiplied by the PE GPCI of 0.929 is 0.94758. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.809 is 0.05663. The sum of 1.97421 is multiplied by the division's 2017 conversion factor of \$57.50 for a MAR of \$113.52.
4. The total allowable reimbursement for the services in dispute is \$426.41. The insurance carrier has paid \$419.44. The amount due to the requestor is \$6.97.

Conclusion

The division would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though not all the evidence was discussed, it was considered.

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 \$6.97.

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 \$6.97, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature

Grayson Richardson
Medical Fee Dispute Resolution Officer

December 14, 2017
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.