



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

VICENTE M JUAN MD

**Respondent Name**

TEXAS MUTUAL INSURANCE COMPANY

**MFDR Tracking Number**

M4-06-6943-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

July 5, 2006

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Should be paid same as co-surgeon . . . Believe reimbursement not sufficient for mod 80."

**Amount in Dispute:** \$9,383.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Texas Mutual's claims paying system reduced the amount of reimbursement . . . due Dr. Vicente's participation in a PPO network through National Choice Care. . . . CCI Edits indicate that code 49010 is global to code 22558. . . . For these reasons Texas Mutual believes no further payment is due."

**Response Submitted by:** Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, Texas 78723

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 12, 2005	Professional Medical Services	\$9,383.00	\$194.13

#### 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 medical fee disputes.
2. 28 Texas Administrative Code §134.202 sets out the fee guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 18 – DUPLICATE CLAIM/SERVICE.
  - 42 – CHARGES EXCEED OUR FEE SCHEDULE OR MAXIMUM ALLOWABLE AMOUNT.
  - 45 – CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
  - 59 – CHARGES ARE ADJUSTED BASED ON MULTIPLE SURGERY RULES OR CONCURRENT ANESTHESIA RULES.
  - 97 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE.
  - 143 – PORTION OF PAYMENT DEFERRED.

- 224 – DUPLICATE CHARGE.
- 329 – ALLOWANCE FOR THIS SERVICE REPRESENTS 50% BECAUSE OF MULTIPLE OR BILATERAL RULES.
- 420 – SUPPLEMENTAL PAYMENT.
- 435 – PER NCCI EDITS, THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF THE COMPREHENSIVE PROCEDURE.
- 790 – THIS CHARGE WAS REDUCED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.
- 793 – REDUCTION DUE TO PPO CONTRACT. PPO CONTRACT WAS APPLIED BY NATIONAL CHOICECARE.
- 891 – THE INSURANCE COMPANY IS REDUCING OR DENYING PAYMENT AFTER RECONSIDERING A BILL.
- W4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.

### **Issues**

1. Is reimbursement for the disputed services subject to a negotiated or contracted amount?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

### **Findings**

1. Per former 28 Texas Administrative Code §134.202(d), effective January 5, 2003, 27 *Texas Register* 4048 and 12304, "In all cases, reimbursement shall be the least of the: (1) MAR amount as established by this rule; (2) health care provider's usual and customary charge; or, (3) health care provider's workers' compensation negotiated and/or contracted amount that applies to the billed service(s)." The insurance carrier denied disputed services with reason codes 42 – "CHARGES EXCEED OUR FEE SCHEDULE OR MAXIMUM ALLOWABLE AMOUNT."; 45 – "CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT."; and 793 – "REDUCTION DUE TO PPO CONTRACT. PPO CONTRACT WAS APPLIED BY NATIONAL CHOICECARE." Review of the submitted information found insufficient documentation to support that reimbursement for the disputed services is subject to a negotiated or contracted amount. Nevertheless, on August 15, 2012, the Division requested the respondent to provide additional information to support the above payment reduction reasons, pursuant to former 28 Texas Administrative Code §133.307(l), effective January 1, 2003, 27 *Texas Register* 12282, which states that "The commission may request other additional information from either party to review the medical fee issues in dispute. The other additional information shall be received by the division within 14 days of receipt of this request." The Division requested the respondent to provide a copy of the referenced contract(s) between the insurance carrier, Texas Mutual Insurance Company and the alleged network, as well as a copy of the contract between the health care provider and the alleged network, and documentation to support that notice had been given to the health care provider that the insurance carrier, Texas Mutual Insurance Company, had been granted access to the contracted fee arrangement between the health care provider and the alleged network. As of the date of this review, the respondent has not provided the additional information requested by the Division; therefore, this decision is based on the information available at the time of the review. The above payment reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to professional surgical services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.202(b), which requires that "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided" with any additions or exceptions as set forth in the rule. Additionally, §134.202(c) requires that "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%." Reimbursement for the disputed services is calculated as follows:
  - Procedure code 63090-62, service date September 12, 2005, performed in Corpus Christi, Texas, has a Medicare payment rate of \$1,771.12. The health care provider billed this procedure code with modifier -62, which indicates services rendered by a co-surgeon. Per Medicare payment policy, services performed by a co-surgeon and billed with modifier -62 are reimbursed at 62.5% of the Medicare fee. This amount is \$1,106.95. Additionally, per the Medicare Physician Fee Schedule, this service has a multiple procedure payment policy indicator of 2, which signifies that this procedure is subject to standard payment adjustment rules for multiple procedures. The highest paying procedure is paid at 100%; payment for additional procedures with indicators of 1, 2, or 3, is reduced by 50%. This procedure is paid at 100%. The adjusted Medicare fee amount is \$1,106.95.00. This amount multiplied by the Division's conversion factor of 125% results in a MAR of \$1,383.69.

- Procedure code 22558-62, service date September 12, 2005, performed in Corpus Christi, Texas, has a Medicare payment rate of \$1,409.28. The health care provider billed this procedure code with modifier -62, which indicates services rendered by a co-surgeon. Per Medicare payment policy, services performed by a co-surgeon and billed with modifier -62 are reimbursed at 62.5% of the Medicare fee. This amount is \$880.80. Additionally, per the Medicare Physician Fee Schedule, this service has a multiple procedure payment policy indicator of 2, which signifies that this procedure is subject to standard payment adjustment rules for multiple procedures. The highest paying procedure is paid at 100%; payment for additional procedures with indicators of 1, 2, or 3, is reduced by 50%. This procedure is paid at 50%. The adjusted Medicare fee amount is \$440.40. This amount multiplied by the Division's conversion factor of 125% results in a MAR of \$550.50.
  - Procedure code 22851-80, service date September 12, 2005, performed in Corpus Christi, Texas, has a Medicare payment rate of \$428.04. The health care provider billed this procedure code with modifier -80, which indicates services rendered by an assistant-at-surgery. Per Medicare payment policy, services performed by an assistant-at-surgery and billed with modifier -80 are reimbursed at 16% of the Medicare fee. This amount is \$68.49. Additionally, per the Medicare Physician Fee Schedule, this service has a multiple procedure payment policy indicator of 0, which signifies that payment adjustment rules for multiple procedures do not apply to this procedure. Reimbursement for this service is therefore not subject to multiple procedure payment reduction. The adjusted Medicare fee amount is \$68.49. This amount multiplied by the Division's conversion factor of 125% results in a MAR of \$85.61.
  - Per Medicare's correct coding initiative edits, procedure code 49010, service date September 12, 2005, is considered a component service of procedure code 22558 performed on the same date. This procedure is not separately reimbursed when billed together with procedure code 22558. Reimbursement is not recommended.
3. The total recommended reimbursement for the services in dispute is \$2,019.80. This amount less the amount previously paid by the insurance carrier of \$1,825.67 leaves an amount due to the requestor of \$194.13. This amount 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 \$194.13.

### **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 \$194.13 plus applicable accrued interest per 28 Texas Administrative Code §134.803, and/or §134.130 if applicable, due within 30 days of receipt of this Order.

### Authorized Signature

	Grayson Richardson	August 14, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

### **YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

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