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
DR T BRADLEY EDWARDS

Respondent Name
PHOENIX INSURANCE CO

MFDR Tracking Number
M4-08-2098-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
NOVEMBER 26, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are disputing the payment submitted for code 23395. Code 23395 is the main procedure. Reimbursement should be 100% of the allowed amount. Applying the multiple procedure rule reduced code 23395. This rule does not apply in this case."

Amount in Dispute: $765.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider's bill involves charges for the services rendered under a contract fee arrangement...Consequently, as this service was paid pursuant to that contract, no additional reimbursement is due."

Respondent's Supplemental Position Summary dated August 27, 2008: "The Carrier has confirmed with First Health that a fee-for-service contract exists between First Health and Dr. Edwards of Fondren Orthopedic Group. The effective date of this contract is 01-01-2007, and covered the date of service at issue, as documented by the Contract Notification Letter attached to the Carrier's Initial Response."

Responses Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 4, 2007	CPT Code 23395	$765.50	$765.50

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, effective August 1, 2003, sets the reimbursement guidelines for the disputed services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

- AFFL, 45-Charges exceed your contracted/legislated fee arrangement. This bill has been reviewed/repriced in accordance with your fee for service contract with First Health.

Issues

1. Does a contractual agreement issue exist in this dispute?
2. Is the requestor entitled to reimbursement?

Findings

1. The issue in dispute is whether or not the requestor is due additional reimbursement for CPT code 23395 rendered on April 4, 2007.

   A review of the submitted billing and explanation of benefits (EOBs) finds that on the disputed date of service, the requestor also billed CPT codes 23130 and 23430. According to EOBs, CPT codes 23130 and 23430 were paid the maximum allowable reimbursement (MAR) per the Division fee guideline, and only CPT code 23395 was reduced in accordance with a contracted or legislated fee arrangement. No documentation was submitted to support a contractual agreement exists between Phoenix Insurance Co. and Dr. T. Bradley Edwards; therefore, the documentation does not support that a contractual agreement exists and reimbursement for the services will be reviewed in accordance with applicable division rules and guidelines.

2. 28 Texas Administrative Code §134.202(b) states "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 in this section."

   CPT code 23395 is defined as "Muscle transfer, any type, shoulder or upper arm; single." A review of the Medicare allowable fee for service rendered on the disputed date finds that CPT code 23395 has the highest rate; therefore, CPT code 23395 is considered the principal procedure and should be paid at 100% of the MAR.

   Per Rule 134.202(b), the MAR is determined by locality. A review of Box 32 on CMS-1500 indicates that the zip code 77030 is the locality. This zip code is located in Houston, Texas.

   28 Texas Administrative Code §134.202(c)(1) states "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: "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%."

   The Medicare allowable for CPT code 23395 in Houston, Texas is $1,256.09. Per 28 Texas Administrative Code §134.202(c)(1) this amount is multiplied by 125% equals a MAR of $1,570.11. The difference between the MAR and amount paid is $765.50. As a result, the amount ordered is $765.50.

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 $765.50.

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 $765.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Elizabeth Pickle
Signature

Elizabeth Pickle, RHIA
Medical Fee Dispute Resolution Officer

May 8, 2014
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.