



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

G. PETER FOOX, MD

Respondent Name

ACE AMERICAN INSURANCE CO

MFDR Tracking Number

M4-11-1598-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

JANUARY 21, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We obtained pre authorization with a number for the procedure. See attached. This pre authorization included the codes we were going to bill. The carrier denied payment stating first that the codes were not correct. Then they denied stating insufficient documentation. They were given ALL the necessary paperwork and could have paid this timely back in May/June of 2010. They are using different reasons for the denial and have not responded to my request for reconsideration in a timely manner."

Amount in Dispute: \$429.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 12, 2010	CPT Code 20553 Injection(s); single or multiple trigger point(s), 3 or more muscle(s)	\$260.00	\$81.42
	CPT Code 99212-25 Office Visit	\$72.00	\$0.00
	CPT Code 99070 Materials & Supplies	\$21.00	\$0.00
	HCPCS Code J2001 Lidocaine HCl, 10mg	\$11.00	\$0.00
	HCPCS Code J1040 Methylprednisolone Acetate, 80 mg	\$65.00	\$0.00
TOTAL		\$429.00	\$81.42

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 §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 16-Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes.

Issues

1. Is the value of code J2001 included in the value of 20553?
2. Does the submitted documentation support code 99212-25?
3. Does the submitted documentation support code 99070?
4. Does the submitted documentation support code J1040?
5. Does the submitted documentation support code 20553?
6. Is the requestor entitled to reimbursement for code 20553?

Findings

1. 28 Texas Administrative Code §134.203(b)(1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."
On the disputed date of service, the requestor billed CPT code 20553, 99070, 99212-25, J2001 and J1040.
According to CCI edits, code J2001 is a component of code 20553; however a modifier is allowed to differentiate the service. A review of the submitted medical bill finds that the requestor did not append a modifier to differentiate the service. As a result, the value of code J2001 is included in the value of 20553. No reimbursement is recommended for code J2001.
2. According to the explanation of benefits, the respondent denied reimbursement for code 99212-25 based upon reason code "16."
The requestor did not submit a separate evaluation and management report to support billing code 99212-25. As a result, no reimbursement is recommended.
3. According to the explanation of benefits, the respondent denied reimbursement for code 99070 based upon reason code "16."
No documentation was submitted to support billing 99070; therefore, reimbursement is not recommended for these services.
4. According to the explanation of benefits, the respondent denied reimbursement for code J1040 based upon reason code "16."
No documentation was submitted to support billing 99070 and J1040; therefore, reimbursement is not recommended for these services
5. According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon reason code "16."
A review of the submitted medical bill finds that the requestor billed for four units of 20553.
A review of the procedure report indicates that the claimant underwent trigger point injections (X4) using 0.2cc 1% Lidocaine. Based upon the code descriptor for 20553, only one unit is recommended for reimbursement.
6. 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 2010 DWC conversion factor for this service is 54.32.

The Medicare Conversion Factor is 36.0791

Review of Box 32 on the CMS-1500 the services were rendered in Tyler, Texas. Per Medicare the provider is reimbursed using the locality of “Rest of Texas”.

The Medicare Participating amount for code 20553 is \$54.08.

Using the above formula, the Division finds the MAR is \$81.42. The respondent paid \$0.00. As a result, the Division finds the requestor is due \$81.42.

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 \$81.42.

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 \$81.42 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

06/18/2014

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.