



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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

BAHZAD AALAEI, MD

Respondent Name

MERGED SAFEGUARD INSURANCE COMPANY
INTO ARROWOOD INDEMNITY

MFDR Tracking Number

M4-11-2400-01

Carrier's Austin Representative

Box Number 11

MFDR Date Received

March 18, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our reimbursement does not involve a private contractual agreement. . . . we terminated our contract with Aetna and First Health/Coventry . . . We would like all of our claims to be paid at the out-of-network rate."

Amount in Dispute: \$56,505.27

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This provider is an out state provider . . . The provider failed to obtain preauthorization previously before the services were rendered and the billing was previously denied for no preauthorization and timely filing. . . . the carrier agreed to process the bills that were denied for timely filing and preauthorization. It is the carrier's position that the charges have been paid correctly in accordance with the Texas Worker's Compensation Fee Schedule."

Response Submitted by: Arrowpoint Capital

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: March 15, 2010, July 12, 2010, July 21, 2010, August 10, 2010, September 9, 2010; Professional Medical Services; \$56,505.27; \$0.00

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 guidelines for professional medical services.
3. 28 Texas Administrative Code §134.1 sets forth general provisions related to medical reimbursement.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - W1: 01 – Workers compensation Fee Schedule Adjustment  
The charge for the procedure exceeds the amount indicated in the fee schedule.
  - W1: D1 – The charge for the prescription drug is greater than the maximum allowable reimbursement for a brandname drug.
  - W1: MJ – The standard pricing method for multiple surgery is denoted by indicator of 2 under the modifier 51 column in the Medicare Physician Fee Schedule Database. The allowance is calculated at:
    - 100 percent for the procedure with the fee schedule amount; and
    - 50 percent for the second through fifth highest fee schedule amounts.Each standard priced procedure after the fifth procedure requires submission of an operative report.
  - W1: 02 – Only the professional component of this service is payable when the place of services is the emergency room, inpatient hospital, outpatient hospital or other facility.

## **Issues**

1. Under what authority is the request for medical fee dispute resolution considered?
2. Did the requestor waive the right to medical fee dispute resolution?
3. Is the requestor entitled to additional reimbursement?

## **Findings**

1. The requestor is a health care provider that rendered disputed services in the state of Indiana to an injured employee with an existing Texas Workers' Compensation claim. The health care provider was dissatisfied with the insurance carrier's final action. The health care provider requested reconsideration from the insurance carrier and was denied payment after reconsideration. The health care provider has requested medical fee dispute resolution under 28 Texas Administrative Code §133.307. Because the requestor has sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the Division concludes that it has jurisdiction to decide the issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules.
2. 28 Texas Administrative Code §133.307(c)(1) requires that:

A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request.

- (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

The dates of the services in dispute are from March 15, 2010 to September 9, 2010. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on March 18, 2011. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution with respect to disputed date of service March 15, 2010. However, disputed dates of service July 12, 2010 through September 9, 2010 were timely filed with the Division and are therefore eligible for review.

3. This dispute regards professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.203(c), which requires that to determine the maximum allowable reimbursement (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 . . .
- (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 Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. The applicable Division conversion factor for calendar year 2010 is \$54.32. For surgery services performed in a facility setting, the conversion factor is \$68.19.

Note: disputed services provided August 10, 2010 were performed in a facility setting (place of service code 22), whereas the place of service for all other disputed dates was an office setting (place of service code 11). Accordingly, the conversion factor for surgery services performed in the facility setting on August 10, 2010 is \$68.19. The conversion factor for all other services is \$54.32.

Reimbursement is calculated as follows:

- Procedure code 62368, service date July 12, 2010, represents analysis of spinal infusion pump, a professional service with reimbursement determined per Rule §134.203(c). For this procedure, the relative value (RVU) for work of 0.75 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.75. The practice expense (PE) RVU of 0.68 multiplied by the PE GPCI of 0.96 is 0.6528. The malpractice RVU of 0.05 multiplied by the malpractice GPCI of 0.599 is 0.02995. The sum of 1.43275 is multiplied by the Division conversion factor of \$54.32 for a MAR of \$77.83. The insurance carrier paid \$78.35.
- Procedure code 95991, service date July 12, 2010, represents spinal pump refill and maintenance, a professional service with reimbursement determined per Rule §134.203(c). For this procedure, the relative value (RVU) for work of 0.77 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.77. The practice expense (PE) RVU of 1.75 multiplied by the PE GPCI of 0.96 is 1.68. The malpractice RVU of 0.04 multiplied by the malpractice GPCI of 0.599 is 0.02396. The sum of 2.47396 is multiplied by the Division conversion factor of \$54.32 for a MAR of \$134.39. The insurance carrier paid \$133.50.
- Procedure code J2275, service date July 12, 2010, Morphine sulfate injection, has status indicator E denoting codes excluded from the CMS Fee Schedule by regulation. CMS does not determine a price or relative value for these services. If reimbursement is justified, these services are paid at a fair and reasonable rate. This code is not assigned a relative value or payment amount. Per §134.203(f), reimbursement is provided in accordance with 28 Texas Administrative Code §134.1 regarding fair and reasonable reimbursement. Review of the submitted information finds insufficient documentation to support a different payment amount from that determined by the insurance carrier; therefore, additional reimbursement is not recommended. The insurance carrier allowed \$1,442.80.
- Procedure code S0020, service date July 12, 2010, injection of bupivacaine hydrochloride, has status indicator I denoting codes that are not valid for Medicare purposes. Medicare uses another code for the reporting and payment of these services. Reimbursement is not recommended.
- Per Medicare policy, procedure code A4220, service date July 12, 2010, infusion pump refill kit, may not be reported with procedure code 95991 billed on this same claim. Payment for this service is included in the payment for the primary procedure(s). Reimbursement is not recommended.
- Procedure code 93005, service date July 12, 2010, represents electrocardiogram tracing, a professional service with reimbursement determined per Rule §134.203(c). For this procedure, the relative value (RVU) for work of 0 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0. The practice expense (PE) RVU of 0.29 multiplied by the PE GPCI of 0.96 is 0.2784. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.599 is 0.00599. The sum of 0.28439 is multiplied by the Division conversion factor of \$54.32 for a MAR of \$15.45. The insurance carrier paid \$15.39.

- Procedure code 94761, service date July 12, 2010, blood oxygen level, has status indicator T denoting conditionally bundled services. This service is only paid if no other payable services are billed for the same date; otherwise, payment for this service is included in the payment for the primary procedures performed. Reimbursement is not recommended. However, the insurance carrier paid \$5.68.
- Procedure code 80101, service date July 12, 2010, represents a pathology/laboratory service with reimbursement determined per Rule §134.203(e). The fee listed for this code in the Medicare Clinical Fee Schedule is \$19.72. 125% of this amount is \$24.65 at 5 units is \$123.25. The insurance carrier paid \$35.73
- Procedure code 77002, service date July 12, 2010, represents x-ray needle localization, a professional service with reimbursement determined per Rule §134.203(c). For this procedure, the relative value (RVU) for work of 0.54 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.54. The practice expense (PE) RVU of 1.36 multiplied by the PE GPCI of 0.96 is 1.3056. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.599 is 0.01797. The sum of 1.86357 is multiplied by the Division conversion factor of \$54.32 for a MAR of \$101.23. The insurance carrier paid \$100.51.
- Procedure code 62284, service date July 21, 2010, represents myelogram injection, a professional service with reimbursement determined per Rule §134.203(c). For this procedure, the relative value (RVU) for work of 1.54 multiplied by the geographic practice cost index (GPCI) for work of 1 is 1.54. The practice expense (PE) RVU of 3.99 multiplied by the PE GPCI of 0.96 is 3.8304. The malpractice RVU of 0.13 multiplied by the malpractice GPCI of 0.599 is 0.07787. The sum of 5.44827 is multiplied by the Division conversion factor of \$54.32 for a MAR of \$295.95. The insurance carrier paid \$417.07.
- Procedure code 72265, service date July 21, 2010, represents contrast x-ray, lower spine, a professional service with reimbursement determined per Rule §134.203(c). The insurance carrier denied this disputed services with reason code: W1: 02 – "Only the professional component of this service is payable when the place of services is the emergency room, inpatient hospital, outpatient hospital or other facility." Review of the submitted information finds that the documentation presented was not sufficient to support the service as billed. Additional reimbursement cannot be recommended.
- Procedure code Q9966, service date July 21, 2010, low osmolar contrast material (iodine), has status indicator E denoting codes excluded from the CMS Fee Schedule by regulation. CMS does not determine a price or relative value for these services. If reimbursement is justified, these services are paid at a fair and reasonable rate. This code is not assigned a relative value or payment amount. Per §134.203(f), reimbursement is provided in accordance with 28 Texas Administrative Code §134.1 regarding fair and reasonable reimbursement. Review of the submitted information finds insufficient documentation to support a different payment amount from that determined by the insurance carrier; therefore, additional reimbursement is not recommended. The insurance carrier allowed \$0.41.
- Procedure code A4550, service date July 21, 2010, has a status indicator of B, which denotes a bundled code. Payments for these services are always bundled into payment for other services to which they are incident.
- Procedure code 93005, service date July 21, 2010, represents a professional service with reimbursement determined per Rule §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0. The practice expense (PE) RVU of 0.29 multiplied by the PE GPCI of 0.96 is 0.2784. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.599 is 0.00599. The sum of 0.28439 is multiplied by the Division conversion factor of \$54.32 for a MAR of \$15.45. The insurance carrier paid \$15.39.
- Procedure code 94761, service date July 21, 2010, has status indicator T denoting conditionally bundled services. This service is only paid if no other payable services are billed for the same date; otherwise, payment for this service is included in the payment for the primary procedures performed. However, the insurance carrier paid \$5.68.

- Procedure code S0020, service date July 21, 2010, injection of bupivacaine hydrochloride, has status indicator I denoting codes that are not valid for Medicare purposes. Medicare uses another code for the reporting and payment of these services. Reimbursement cannot be recommended.
- Procedure code 62368, service date July 21, 2010, represents analysis of spinal infusion pump, a professional service with reimbursement determined per Rule §134.203(c). For this procedure, the relative value (RVU) for work of 0.75 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.75. The practice expense (PE) RVU of 0.68 multiplied by the PE GPCI of 0.96 is 0.6528. The malpractice RVU of 0.05 multiplied by the malpractice GPCI of 0.599 is 0.02995. The sum of 1.43275 is multiplied by the Division conversion factor of \$54.32 for a MAR of \$77.83. The insurance carrier paid \$78.35.
- Procedure code 62355, service date August 10, 2010, represents removal of spinal catheter, a professional service with reimbursement determined per Rule §134.203(c). For this procedure, the relative value (RVU) for work of 4.35 multiplied by the geographic practice cost index (GPCI) for work of 1 is 4.35. The practice expense (PE) RVU of 2.8 multiplied by the PE GPCI of 0.96 is 2.688. The malpractice RVU of 0.54 multiplied by the malpractice GPCI of 0.599 is 0.32346. The sum of 7.36146 is multiplied by the Division conversion factor of \$68.19 for a MAR of \$501.98. This procedure has a multiple procedure indicator of 2, designating procedures subject to Medicare payment adjustment rules regarding multiple procedures. If this procedure is reported on the same day as another procedure with indicator 1, 2, or 3, the highest paying of the procedures is paid at 100% of the fee schedule, and each additional such procedure (up to 4) is paid at 50%. This procedure was performed on the same day as procedure code 62350, which is the higher paying service. Procedure code 62350 is therefore paid at 100% and payment for this service is reduced by 50%, for a recommended reimbursement of \$250.99. The insurance carrier paid \$257.66.
- Procedure code 62350, service date August 10, 2010, represents implantation of spinal catheter, a professional service with reimbursement determined per Rule §134.203(c). For this procedure, the relative value (RVU) for work of 6.05 multiplied by the geographic practice cost index (GPCI) for work of 1 is 6.05. The practice expense (PE) RVU of 3.38 multiplied by the PE GPCI of 0.96 is 3.2448. The malpractice RVU of 0.77 multiplied by the malpractice GPCI of 0.599 is 0.46123. The sum of 9.75603 is multiplied by the Division conversion factor of \$68.19 for a MAR of \$665.26. This procedure has a multiple procedure indicator of 2, designating procedures subject to Medicare payment adjustment rules regarding multiple procedures. If this procedure is reported on the same day as another procedure with indicator 1, 2, or 3, the highest paying of the procedures is paid at 100% of the fee schedule, and each additional such procedure (up to 4) is paid at 50%. This procedure is the highest paying procedure; therefore, it is paid at 100%. The recommended payment is \$665.26. The insurance carrier paid \$685.12.
- Procedure code 62368, service date August 10, 2010, represents analysis of spinal infusion pump, a professional service with reimbursement determined per Rule §134.203(c). For this procedure, the relative value (RVU) for work of 0.75 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.75. The practice expense (PE) RVU of 0.22 multiplied by the PE GPCI of 0.96 is 0.2112. The malpractice RVU of 0.05 multiplied by the malpractice GPCI of 0.599 is 0.02995. The sum of 0.99115 is multiplied by the Division conversion factor of \$68.19 for a MAR of \$67.59. The insurance carrier paid \$68.88.
- Procedure code 77003-26, service date August 10, 2010, represents the professional component of fluoroscopic guidance for spine injection, a professional service with reimbursement determined per Rule §134.203(c). For this procedure, the relative value (RVU) for work of 0.6 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.6. The practice expense (PE) RVU of 0.17 multiplied by the PE GPCI of 0.96 is 0.1632. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.599 is 0.01198. The sum of 0.77518 is multiplied by the Division conversion factor of \$54.32 for a MAR of \$42.11. The insurance carrier paid \$42.43.
- Procedure code 95991, service date August 10, 2010, represents spinal pump refill and maintenance, a professional service with reimbursement determined per Rule §134.203(c). For this procedure, the relative value (RVU) for work of 0.77 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.77. The practice expense (PE) RVU of 0.21 multiplied by the PE GPCI of 0.96 is 0.2016. The malpractice RVU of 0.04 multiplied by the malpractice GPCI of 0.599 is 0.02396. The sum of 0.99556 is multiplied by the Division conversion factor of \$54.32 for a MAR of \$54.08. The insurance carrier paid \$54.86.

- Procedure code 62368, service date September 9, 2010, represents analysis of spinal infusion pump, a professional service with reimbursement determined per Rule §134.203(c). For this procedure, the relative value (RVU) for work of 0.75 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.75. The practice expense (PE) RVU of 0.68 multiplied by the PE GPCI of 0.96 is 0.6528. The malpractice RVU of 0.05 multiplied by the malpractice GPCI of 0.599 is 0.02995. The sum of 1.43275 is multiplied by the Division conversion factor of \$54.32 for a MAR of \$77.83. The insurance carrier paid \$68.88.

The total recommended reimbursement for the services in dispute is \$3,442.45. The submitted documentation supports that the insurance carrier has paid \$3,506.69 toward these services. No additional reimbursement is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

**Authorized Signature**

	Grayson Richardson	February 26, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

	Martha Luévano	February 26, 2016
Signature	Medical Fee Dispute Resolution Manager	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 MFDR 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 this *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.**