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. PETER E. GRAYS

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-11-4416-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
AUGUST 1, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Texas Mutual insurance has denied the payment for procedure code 55520.59.LT, Excision of Left Spermatic Cord Lipoma. This has been sent back for reconsideration for payment and they have maintained their original decision of payment. I am requesting for this procedure code to be considered for proper payment for the services rendered."

Amount in Dispute: $459.94

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual maintains its position, as communicated through its EOBs, that no further payment is due."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 21, 2010	CPT Code 55520-59-LT Excision of lesion of spermatic cord (separate procedure)	$459.94	$180.99

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:
   - CAC-B5-Covereage/program guidelines were not met or were exceeded.
   - CAC-59-Porcessed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)
   - 329-Allowance for this service represents 50% because of multiple or bilateral rules.
   - 757-Network reduction based on Focus healthcare contract.

- CAC-131-Claim specific negotiated discount.
- CAC193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- CAC-45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use group codes PR or CO depending upon liability).
- 724-No additional payment after a reconsideration of services.
- 729-This bill was reviewed in accordance with your First Health contract.

Issues

1. Does the submitted documentation support that a contractual agreement issue exist in this dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code "757-Network reduction based on Focus healthcare contract." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. A review of the submitted documentation finds that the respondent paid $217.50 for code 55520-59-LT. The requestor asserts that additional reimbursement of $459.94 is due.

   Per 28 Texas Administrative Code §134.203(b)(1) "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 codes 49507-LT and 55520-59-LT.

   The requestor appended modifier "59-Distinct Procedural Service" to code 55520. According to the CCI edits, CPT code 55520 is a component of code 49507 effective April 1, 2011. Because the disputed date of service was prior to this edit, the Division finds that code 55520 is not a component of 49507. Reimbursement for code 55520 will be based upon Division fee guideline.

   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 68.19.

   The Medicare Conversion Factor is 36.8729

   Review of Box 32 on the CMS-1500 the services were rendered in Fort Worth, Texas; therefore, the Medicare participating amount is based upon the locality of "Fort Worth, Texas".

   The Medicare Participating amount is $430.96.

   CPT code 55520 is subject to multiple procedure discounting.

Using the above formula the MAR for code 55520 is $796.98 X 50% = $398.49. The respondent paid $217.50. The difference between the MAR and paid is $180.99; this amount is recommended for additional reimbursement.

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 $180.99.

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 $180.99 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		06/06/2014
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.