



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

FONDREN ORTHOPEDIC GROUP, LLP
J. BRYAN WILLIAMSON, MD

Respondent Name

INSURANCE CO OF THE STATE OF PA

MFDR Tracking Number

M4-15-1040-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

DECEMBER 1, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Code 22633 not bundled to either 63042/59 or 63030/59. Both the 63042 and 63030 are for decompression of the severe foraminal stenosis whereas 22633 is for the spinal fusion of the L5-S1 intervertebral level due to recurrent disk herniation. 22633 does not include work done to decompress the nerve nor re-exploration of the nerves for decompression hence this bundling is not justified. Therefore, procedure code 22633 is subject for payment and is not considered a bundled procedure."

Amount in Dispute: \$3,701.38

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Requestor shows a billed amount of \$5,200.00 on the DWC 060 and a disputed amount of \$3,701.38. The DWC060 shows no payment by the carrier. Attached find Explanation of Bill Review forms from the carrier showing a total payment for this date of service of \$8,430.77. The Explanation of Service forms explain the carrier reimbursement amounts."

Response Submitted by: AIG

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: April 8, 2014, CPT Code 22633 Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar, \$3,701.38, \$1,751.74

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 a medical fee dispute.

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:
 - W1-Workers compensation state fee schedule adjustment.
 - VRNA-No reduction available.
 - 97-The benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated.
 - P300-The amount paid reflects a fee schedule reduction.
 - Z710-The charge for this procedure exceeds the fee schedule allowance.
 - VA08-This procedure is incidental to the primary procedure, and does not warrant separate reimbursement.
 - W3-Requesto for reconsideration.
 - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is the allowance of CPT code 22633 included in the allowance of another service/procedure billed on the disputed date of service?
2. Is the requestor entitled to additional reimbursement?

Findings

1. According to the explanation of the respondent denied reimbursement for CPT code 22633 based upon reason codes “97” and “VA08.”

On the disputed date of service, the requestor billed codes 63056-59, 22633, 22840, 22851, 20930, 20936, 63042-59, 63030-59 and 62350.

28 Texas Administrative Code §134.203(a)(5) states “Medicare payment policies” when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.”

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: (1) 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.”

Per CCI edits, CPT code 22633 is not a component of any other procedure performed on the disputed date; therefore, the respondent’s denial based upon reason codes “97” and “VA08” is not supported.

2. 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 2014 DWC conversion factor for this service is 69.98.

The Medicare Conversion Factor is 35.8228

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77030, which is located in Houston, TX; therefore, the Medicare participating amount is based on locality “Houston, Texas”.

The Medicare participating amount for code 22633 is \$1,792.85.

Code 22633 is subject to multiple procedure rule (MPR) discounting. Based upon the submitted explanation of benefits, the respondent paid code 63056 at 100%.

Using the above formula, the MAR is \$3,502.34 X 50% MPR = \$1,751.74. 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 \$1,751.74.

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 \$1,751.74 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	05/14/2015 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request 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 §141.1(d).

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