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 Gp LLP

Respondent Name
Liberty Insurance Corporation

MFDR Tracking Number
M4-15-3166-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
May 27, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We disagree with the amount paid as it appears to be paid as a non Facility setting and this was done in a Facility setting."

Amount in Dispute: $52.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Medicare reimbursement is $140.03 in either a Facility of Non-Facility setting. DWC fee schedule reimbursement amount is determined by multiplying the Medicare rate by the 2015 Division Ratio (Division Conversion Factor Divided by the CMS Conversion Factor).

$140.03 X 1.5718 (2015 Division Ration) = $220.10

Reimbursement was made according to Division requirements. No additional reimbursement is due."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 19, 2015	Evaluation & Management, In hospital care	$52.68	$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 guidelines for billing and reimbursement of professional medical services.
3. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of a medical bill.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 45 – Not defined as required in 28 Texas Administrative Code §133.240
   - Z710 – The charge for this procedure exceeds the fee schedule allowance.
   - P300 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - W3 – Additional payment made on appeal/reconsideration

Issues

1. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.203 (b) 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."

   Procedure code 99222, service date February 19, 2015, represents a professional service with reimbursement determined using the conversion factor calculated according to §134.203(c)(2). The conversion factor for 2015, per Commissioner's Bulletin # B-0023-14 is $56.20. 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 2.61 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 2.65959. The practice expense (PE) RVU of 1.05 multiplied by the PE GPCI of 1.006 is 1.0563. The malpractice RVU of 0.21 multiplied by the malpractice GPCI of 0.955 is 0.20055. The sum of 3.91644 is multiplied by the Division conversion factor of $56.20 for a MAR of $220.10.
2. The MAR for the disputed services is $220.10. The insurance carrier paid $220.10. No further 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 reimbursement for the disputed services.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	June 23, 2015 Date

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.