



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, L.L.P.

Respondent Name

New Hampshire Insurance Company

MFDR Tracking Number

M4-15-3433-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

June 12, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim was denied as being global to the surgery but surgery was performed back in May 2014 which only has a 90 day global period. So when the provider seen this patient on this date the global period doesn't apply."

Amount in Dispute: \$112.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the Carrier's position that the 11/11/2014 date of service billed for \$112.25; is not owed to the requestor..."

Response Submitted by: AIG

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: November 11, 2014, Evaluation & Management, established patient (99213), \$112.25, \$108.33

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 reimbursing professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- 1 - Non-covered charge(s).
- 2 - The provider billed for an evaluation and management service on the same day or within the follow-up period of a surgical procedure.

**Issues**

1. Are the insurance carrier’s reasons for denial or reduction of payment supported?
2. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

**Findings**

1. The insurance carrier denied disputed services with claim adjustment reason codes “1 – Non-covered charge(s),” and “2 – The provider billed for an evaluation and management service on the same day or within the follow-up period of a surgical procedure.” 28 Texas Administrative Code §133.307 (d)(2) states, in relevant part, “...Upon receipt of the request, the respondent shall provide any missing information not provided by the requestor and known to the respondent ...”

Review of the submitted information does not find documentation that supports that CPT Code 99213 is not a payable code or that is part of the global period for another procedure. The insurance carrier’s denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. The disputed service is a professional service subject to the fee guidelines found in 28 Texas Administrative Code §134.203, which states, in relevant part, “(b) 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.” 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 Division conversion factor for 2014 is \$55.75.

For CPT Code 99213 on November 11, 2014, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.000 is 0.97. The practice expense (PE) RVU of 1.00 multiplied by the PE GPCI of 0.916 is 0.916. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.816 is 0.057120. The sum of 1.943120 is multiplied by the Division conversion factor of \$55.75 for a MAR of \$108.33.

3. The total MAR for the disputed service is \$108.33. The insurance carrier paid \$0.00. A reimbursement of \$108.33 is recommended.

**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 \$108.33.

***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 \$108.33 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

	Laurie Garnes	July 15, 2015
Signature	Medical Fee Dispute Resolution Officer	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.**