



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

Mark H. Henry, M.D.

Respondent Name

New Hampshire Insurance Company

MFDR Tracking Number

M4-15-4021-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

August 12, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We find that procedure code 99285 billed on the claim and procedure code 73130 were not paid at 100% of the statutory fee as required by law per Texas Administrative Code Title 28 Part 2 Chapter 134 Subchapter C Rule 134.202."

Amount in Dispute: \$411.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bills have been processed again and another check was issued in the amount of \$14.05 for the x-ray (procedure code 73130) that is being requested. So, the Carrier is going to maintain their denial that an additional \$343.07 is owed for an ER visit the same day as her surgery to the requestor..."

Response Submitted by: AIG Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 24, 2015	Evaluation & Management (99285-57) Radiology (73130-26)	\$411.90	\$272.54

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - Workers Compensation State Fee Schedule Adjustment.

- The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- A charge for the interpretation of a diagnostic procedure (modifier 26 and or 76140 for radiology) has already been paid or is included in the examination services rendered on this date.
- The value of the procedure is included in the value of another procedure performed on this date.
- A charge for an evaluation on the same day as a surgical procedure has not been paid. Modifier 25 was used to identify a significant, separately identifiable evaluation and management service. A report must be submitted.
- Procedure was partially or fully furnished by another provider.
- DUPLICATE CHARGE
- A reduction was made because a different provider has billed for the exact services on a previous bill.
- The provider or a different provider has billed for the exact service on a previous bill where no allowance was originally recommended.

Issues

1. What are the services in dispute?
2. What is the correct rule to evaluate the disputed services?
3. Are the insurance carrier's reasons for denial of payment for procedure code 99285-57 supported?
4. Are the insurance carrier's reasons for denial of payment for procedure code 73130-26 maintained?
5. What is the maximum allowable reimbursement (MAR) for the disputed services?
6. Is the requestor entitled to additional reimbursement?

Findings

1. While surgical procedure codes 26676-F4, 26727-F2, and 26727-F3 were included on the Medical Fee Dispute Resolution Request (DWC060), the requestor lists the amount in dispute for these codes as \$0.00. Therefore, these services will not be considered for this dispute. The dispute includes procedure codes 99285-57 and 73130-26.
2. 28 Texas Administrative Code §134.203(a) states,

Applicability of this rule is as follows:

 - (1) This section applies to professional medical services provided in the Texas workers' compensation system, other than:
 - (A) workers' compensation specific codes, services, and programs described in §134.204 of this title (relating to Medical Fee Guideline for Workers' Compensation Specific Services);
 - (B) prescription drugs or medicine;
 - (C) dental services;
 - (D) the facility services of a hospital or other health care facility; and
 - (E) medical services provided through a workers' compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in Insurance Code Chapter 1305.
 - (2) This section applies to professional medical services provided on or after March 1, 2008.
 - (3) For professional services provided between August 1, 2003 and March 1, 2008, §134.202 of this title ... applies.
 - (4) For professional services provided prior to August 1, 2003, §134.201 of this title ... and §134.302 of this title ...

Review of the submitted documentation finds that 28 Texas Administrative Code §134.203 is the correct rule to evaluate the disputed services.

3. The insurance carrier denied disputed procedure code 99285-57 stating, "A charge for an evaluation on the same day as a surgical procedure has not been paid. Modifier 25 was used to identify a significant, separately identifiable evaluation and management service. A report must be submitted."

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.

Review of the submitted documentation does not find that modifier 25 was used. Submitted documentation finds that the requestor billed with modifier 57. Medicare states that the "initial consultation or evaluation of the problem by the surgeon to determine the need for major surgeries [may be billed and paid for separately]. This is billed separately using the modifier -57 (Decision for Surgery)." The insurance carrier's denial for this reason is not supported.

The insurance carrier also denied procedure code 99285-57 stating, "Procedure was partially or fully furnished by another provider," and "A reduction was made because a different provider has billed for the exact services on a previous bill." Review of the submitted documentation does not support that this service was performed by another provider on the same date of service. The insurance carrier's denial for this reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

4. The insurance carrier denied disputed procedure code 73130-26 with the following denial reasons:

- The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- A charge for the interpretation of a diagnostic procedure (modifier 26 and or 76140 for radiology) has already been paid or is included in the examination services rendered on this date.
- The value of the procedure is included in the value of another procedure performed on this date.

Review of the submitted information finds that the insurance carrier did not maintain the denial of this procedure code, making a partial payment of \$14.05 per the explanation of benefits dated August 28, 2015. The division finds that the insurance carrier did not maintain the denial of this procedure code. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

5. 28 Texas Administrative Code §134.203(c) states,

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...
- (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 Division conversion factor for 2014 is 55.75.

For procedure code 99285 on October 24, 2014, the relative value (RVU) for work of 3.80 multiplied by the geographic practice cost index (GPCI) for work of 1.014 is 3.853200. The practice expense (PE) RVU of 0.76 multiplied by the PE GPCI of 1.004 is 0.763040. The malpractice (MP) RVU of 0.29 multiplied by the MP GPCI of 0.939 is 0.272310. The sum of 4.888550 is multiplied by the Division conversion factor of \$55.75 for a MAR of \$272.54.

For CPT code 73130-26 on October 24, 2014, the RVU for work of 0.17 multiplied by the GPCI for work of 1.014 is 0.172380. The PE RVU of 0.07 multiplied by the PE GPCI of 1.004 is 0.070280. The MP RVU of 0.01 multiplied by the MP GPCI of 0.939 is 0.009390. The sum of 0.252050 is multiplied by the Division conversion factor of \$55.75 for a MAR of \$14.05.

6. The total MAR for the disputed services is \$286.59. The insurance carrier paid \$14.05. A reimbursement of \$272.54 is recommended.

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Even though all the evidence was not discussed, it was considered. 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 \$272.54.

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 \$272.54 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	Laurie Garnes	January 15, 2016
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.