



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

Respondent Name

Liberty Mutual Insurance Corporation

MFDR Tracking Number

M4-16-0068-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

September 10, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I write this letter to you as a requested for reconsideration on the above date of service. Procedure 99213 as we added a 24 modifier..."

Amount in Dispute: \$114.47

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The follow-up was in reference to the procedure on 11/3/2014 for application of the fixator device. The visit is outside of the global period for that surgery..."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 17, 2015	Evaluation & Management, established patient (99213)	\$114.47	\$114.47

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 §133.203 sets out the fee guidelines for professional medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - U034 – A charge was made for a visit on the same day as a surgical procedure, or within the 90 day follow up period of a previously performed surgery.
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

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

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code U034 – "A CHARGE WAS MADE FOR A VISIT ON THE SAME DAY AS A SURGICAL PROCEDURE, OR WITHIN THE 90 DAY FOLLOW UP PERIOD OF A PREVIOUSLY PERFORMED SURGERY." 28 Texas Administrative Code §133.307 (d)(2)(E) requires that the insurance carrier provide the following in their response: "a statement of the disputed fee issue(s), which includes: ... (ii) a position statement of reasons why the disputed medical fees should not be paid ..."

Review of the submitted information finds that the insurance carrier acknowledged in their position statement that "the visit is outside of the global period for [the relevant] surgery..." The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. 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 2015 is \$56.20.

For CPT code 99213 on April 17, 2015, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.014 is 0.983580. The practice expense (PE) RVU of 1.00 multiplied by the PE GPCI of 1.004 is 1.004000. The malpractice (MP) RVU of 0.07 multiplied by the MP GPCI of 0.939 is 0.065730. The sum of 2.053310 is multiplied by the Division conversion factor of \$56.20 for a MAR of \$115.40.

3. 28 Texas Administrative Code §133.203 (h) states, in relevant part:

When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the:

- (1) MAR amount;
- (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount...

The MAR for the disputed services is \$115.40. The requestor is seeking \$114.47. The insurance carrier paid \$0.00. A reimbursement of \$114.47 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 \$114.47.

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 \$114.47 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	<u>Laurie Garnes</u>	<u>October 23, 2015</u>
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.