



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

Ferral Endsley, D.O.

Respondent Name

New Hampshire Insurance Company

MFDR Tracking Number

M4-16-0934-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

December 10, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We were only paid for the office visit even though the HCFA clearly states this was for an impairment rating."

Amount in Dispute: \$300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "At this time we have escalated this to our bill review vendor for an additional review to determine if payment is due."

Response Submitted by: Cannon Cochran Management Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 24, 2015	Treating Doctor Examination to Determine Maximum Medical Improvement and Impairment Rating	\$300.00	\$300.00

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

- 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.
- 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12 – Workers' compensation jurisdictional fee schedule adjustment.
 - 309 – The charge for this procedure exceeds the fee schedule allowance.
 - 193 – Original payment decision is being maintained. This claim was processed properly the first time.

- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. What is the maximum allowable reimbursement (MAR) for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for CPT code 99455-V3-WP. 28 Texas Administrative Code §134.204(j)(3) states, in relevant part:

The following applies for billing and reimbursement of an MMI evaluation.

(A) An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier.

- (i) Reimbursement shall be the applicable established patient office visit level associated with the examination.
- (ii) Modifiers "V1", "V2", "V3", "V4", or "V5" shall be added to the CPT code to correspond with the last digit of the applicable office visit.

The requestor billed the disputed services with modifier "V3." This corresponds with established office visit 99213. The MAR for CPT code 99213 is subject to the fee guidelines found in 28 Texas Administrative Code §134.203. 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 September 24, 2015, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.000 is 0.970000. The practice expense (PE) RVU of 1.01 multiplied by the PE GPCI of 0.920 is 0.929200. The malpractice (MP) RVU of 0.06 multiplied by the MP GPCI of 0.822 is 0.049320. The sum of 1.948520 is multiplied by the Division conversion factor of \$56.20 for a MAR of \$109.51.

Per 28 Texas Administrative Code §134.204(j)(4), "The following applies for billing and reimbursement of an IR evaluation. ... (C)(ii) The MAR for musculoskeletal body areas shall be as follows. ... (II) If full physical evaluation, with range of motion, is performed: (-a-) \$300 for the first musculoskeletal body area." The submitted documentation indicates that the requestor provided an impairment rating, which included a musculoskeletal body part, and performed a full physical evaluation with range of motion of the right upper extremity. Therefore, the correct MAR for this examination is \$300.00.

2. 28 Texas Administrative Code §134.204(j)(2)(C) states, "If the examining doctor determines MMI has been reached and an IR evaluation is performed, both the MMI evaluation and the IR evaluation portions of the examination shall be billed and reimbursed in accordance with paragraphs (3) and (4) of this subsection."

The total MAR for the disputed services is \$409.51. The insurance carrier paid \$109.51. An additional reimbursement of \$300.00 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 \$300.00.

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 \$300.00 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 11, 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.