



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

ORTHOTEXAS PHYSICIANS & SURGEONS, PLLC

Respondent Name

MITSUI SUMITOMO INSURANCE COMPANY OF AMERICA

MFDR Tracking Number

M4-16-1300-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

January 15, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Attached is everything needed for consideration of this claim(s). Please review and process for payment."

Amount in Dispute: \$4,061.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier issued reimbursement in the amount of \$1,326.31 under CTP 29876. Carrier denied that reimbursement was owed under CPT 29881 and 29877 because of billing errors. The billed codes did not match with the services performed. . . . Carrier maintains that it made appropriate reductions from the billed amounts and that additional reimbursement is not owed."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: July 30, 2015, Professional Medical Services, Procedure Codes: 29876, 29881, \$4,061.00, \$1,586.35

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 fee guideline for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 16 – Svc lacks info needed or has billing error(s)
 - B13 – Payment for service may have been previously paid
 - 193 – Original payment decision is maintained
 - LT – Left Side
 - W3 – Appeal/Reconsideration.

Issues

1. Did the respondent support that the insurance carrier has issued payment for the disputed services?
2. Are the insurance carrier's denial reasons supported?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code B13 – “Payment for service may have been previously paid.” The respondent’s position statement asserts, “Carrier issued reimbursement in the amount of \$1,326.31 under CTP 29876.”

The requestor’s *Table of Disputed Services* (Form DWC060) indicates no payment received for the disputed services. Nor do the three explanations of benefits (EOBs) submitted by the requestor reflect any payments made by the insurance carrier for the disputed services.

28 Texas Administrative Code §133.307(d) requires that responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division. Paragraph (d)(1) further provides that “If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.”

Moreover, §133.307(d)(2)(B) requires that the respondent shall provide any missing information not provided by the requestor and known to the respondent, including “a paper copy of all initial and appeal EOBs related to the dispute, as originally submitted to the health care provider . . . ”

The respondent did not submit copies of any additional records or missing EOBs for consideration in this review. Based on the submitted documentation, the respondent has failed to support any payment for the services in dispute.

2. The insurance carrier denied disputed services with claim adjustment reason code 16 – “Svc lacks info needed or has billing error(s).” The respondent did not explain or provide documentation to support what information was lacking or needed, or what billing error(s) had been made. Review of the submitted documentation finds that the disputed services are supported as billed. The disputed services will therefore be reviewed for payment according to applicable Division rules.
3. This dispute regards professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.203(c), which requires that:

To determine the MAR [Maximum Allowable Reimbursement] 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 applicable Division conversion factor for surgery performed in a facility setting for 2015 is \$70.54. Reimbursement is calculated as follows:

- Procedure code 29876 represents arthroscopic synovectomy of the knee. For this procedure, the relative value (RVU) for work of 8.87 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 9.02966. The practice expense (PE) RVU of 8.27 multiplied by the PE GPCI of 1.009 is 8.34443. The malpractice RVU of 1.85 multiplied by the malpractice GPCI of 0.772 is 1.4282. The sum of 18.80229 is multiplied by the Division conversion factor of \$70.54 for a MAR of \$1,326.31. Per *Medicare Claims Processing Manual*, CMS Publication 100-04, Chapter 12, §40.6, C.13, special rules for multiple endoscopic procedures apply. If the billed procedures share the same endoscopic base code, the highest valued endoscopy is paid in full, plus the difference between the next highest and the base endoscopy. Both these billed procedures share base endoscopy code 29870. This procedure has the highest value; therefore this service is paid in full. The recommended reimbursement is \$1,326.31.
- Procedure code 29881 represents knee arthroscopy with meniscectomy. For this procedure, the relative value (RVU) for work of 7.03 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 7.15654. The practice expense (PE) RVU of 7.18 multiplied by the PE GPCI of 1.009 is 7.24462. The malpractice RVU of 1.38 multiplied by the malpractice GPCI of 0.772 is 1.06536. The sum is 15.46652. Per *Medicare Claims Processing Manual*, CMS Publication 100-04, Chapter 12, §40.6, C.13, special rules for multiple endoscopic procedures apply. If the billed procedures share the same endoscopic base code, the highest valued endoscopy is paid in full, plus the difference between the next highest and the base endoscopy. Both billed procedures share base endoscopy code 29870. This is the next highest valued procedure; therefore the value of the base code 29870 is deducted from the value of this procedure before calculating payment.

For endoscopic base procedure 29870, the relative value (RVU) for work of 5.19 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 5.28342. The practice expense (PE) RVU of 5.62 multiplied by the PE GPCI of 1.009 is 5.67058. The malpractice RVU of 1.07 multiplied by the malpractice GPCI of 0.772 is 0.82604. The sum is 11.78004.

- The sum of 11.78004 for endoscopic base procedure 29870 is subtracted from the value for disputed procedure code 29881 of 15.46652. The difference is 3.68648. This amount is multiplied by the Division conversion factor of \$70.54 for a MAR of \$260.04. This amount 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 \$1,586.35.

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 \$1,586.35 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	Grayson Richardson	February 12, 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.