



# 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

**Respondent Name**

ZURICH AMERICAN INSURANCE COMPANY

**MFDR Tracking Number**

M4-16-2045-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

March 18, 2016

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Patient had a cortisone injection under fluoroscopic guidance on this date of service. See attached documentation that supports the services rendered."

**Amount in Dispute:** \$263.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "services are reimbursement as part of reimbursement for other procedures performed on that same date."

**Response Submitted by:** Flahive, Ogden & Latson

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 16, 2015	Wrist Arthrography, Procedure Code 73115	\$263.00	\$169.72

#### 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 guideline for professional medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - B1 (B12) – SERVICES NOT DOCUMENTED IN PATIENTS' MEDICAL RECORDS.
  - P12 – P12
  - Z710 – Z710
  - W3 – W3

## Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the recommended reimbursement for the disputed professional medical services?
3. Is the requestor entitled to additional reimbursement?

## Findings

1. The insurance carrier denied disputed services with claim adjustment reason code B1 (B12) – "SERVICES NOT DOCUMENTED IN PATIENTS' MEDICAL RECORDS." The respondent's position statement asserts, "services are reimbursement as part of reimbursement for other procedures performed on that same date."

28 Texas Administrative Code §134.203(b) requires that for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply "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."

Disputed procedure code 73115 represents a diagnostic radiological arthrography study of the wrist, with contrast, including interpretation. Review of the submitted medical bill finds no CCI edits or other Medicare payment policies to support that payment for this service is included in the reimbursement for other procedures billed for the same date. Review of the submitted medical records finds that the service is documented as performed, and the submitted documentation supports the service as billed. The respondent did not submit documentation to support their position. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed for payment per applicable Division rules and fee guidelines.

2. 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. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.
- (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 a conversion factor. The MAR is calculated by substituting the Division conversion factor. The applicable Division conversion factor for calendar year 2015 is \$56.20.

Reimbursement is calculated as follows:

- Procedure code 73115, service date September 16, 2015, represents a professional service with reimbursement determined per §134.203(c). 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. For this procedure, the relative value (RVU) for work of 0.54 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.54972. The practice expense (PE) RVU of 2.41 multiplied by the PE GPCI of 1.009 is 2.43169. The malpractice RVU of 0.05 multiplied by the malpractice GPCI of 0.772 is 0.0386. The sum of 3.02001 is multiplied by the Division conversion factor of \$56.20 for a MAR of \$169.72.

3. The total allowable reimbursement for the services in dispute is \$169.72. The insurance carrier has paid \$0.00. The amount due to the requestor is \$169.72.

**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 \$169.72.

*ORDER*

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$169.72, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

\_\_\_\_\_  
Signature

Grayson Richardson  
Medical Fee Dispute Resolution Officer

April 13, 2016  
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.**