



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 GP, LLP

Respondent Name

LIBERTY INSURANCE CORP

MFDR Tracking Number

M4-16-3645-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

AUGUST 9, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We disagree with the amount paid as it appears that this claim was not paid using the 2016 TX Fee Schedule."

Amount in Dispute: \$17.94

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As we previously paid \$1368.69, we feel do not feel the provider is due additional reimbursement for this code."

Response Submitted by: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: April 19, 2016, CPT Code 26565-F3, \$17.94, \$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
- Z710-The charge for this procedure exceeds the fee schedule allowance.
- P300-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.

- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3-Additional payment made on appeal/reconsideration.

Issues

Is the requestor entitled to additional reimbursement?

Findings

The issue in dispute is whether the requestor is due additional reimbursement of \$17.94 for CPT code 26565-F3 rendered on April 19, 2016.

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...”

The Requestor billed CPT code “26565-Osteotomy; metacarpal, each.”

Per 28 Texas Administrative Code §134.203(c)(1)(2), “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. 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 following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007.”

To determine the MAR the following formula is used: $(DWC \text{ Conversion Factor} / Medicare \text{ Conversion Factor}) \times Participating \text{ Amount} = Maximum \text{ Allowable Reimbursement (MAR)}$.

The 2016 DWC conversion factor for this service is 71.32.

The Medicare Conversion Factor is 35.8043

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77030, which is located in Houston, Texas; therefore, the Medicare participating amount is based on locality “Houston, Texas”.

The Medicare participating amount \$687.12.

Using the above formula, the Division finds the MAR is \$1,368.69. The respondent paid \$1,368.69. The difference between the MAR and amount paid is \$0.00. The division therefore finds that the requestor is not entitled to additional reimbursement.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

08/25/2016

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.