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
TEXAS ALLIANCE MEDICAL GROUP

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-18-3663-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
MAY 29, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim resubmitted has been corrected by down coding the office visit to 99203 and the xray should not have been denied initially, the procedure: clearly states: AP view of the right shoulder is submitted in internal and external rotation which is correctly identified according to the coding initiative."

Amount in Dispute: $392.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider initially up-coded the office visit under CPT code 99204. The provider subsequently submitted a second CMS-1500 that indicated that the CPT code 99204 was being down-coded to 99203. The provider is currently seeking reimbursement of $392.00…The provider is not entitled to any additional reimbursement because either the information submitted does not support the level of service or the provider's documentation lacks information to support any reimbursement. The provider is not entitled to any additional reimbursement."

Response Submitted by: Flahive, Ogden & Latson.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 22, 2017	CPT Code 73030-RT	$143.00	$47.62
	CPT Code 99203 Office Visit	$249.00	$177.31
TOTAL		$392.00	$224.93

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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 00403, 112-Service not furnished directly to the patient and/or not documented.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - P300-The amount paid reflects a fee schedule reduction.
   - 16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.

Issues

1. Does the documentation support billing CPT code 99203? Is the requestor due reimbursement for CPT code 99203?
2. Does the documentation support billing CPT code 73030-RT? Is the requestor due reimbursement for CPT code 73030-RT?
3. What is the appropriate reimbursement for CPT code 99203 and 73030-RT?

Findings

1. The insurance carrier denied reimbursement for the office visit, CPT code 99203, based upon reason code "16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication."

   The respondent contends that reimbursement is not due based upon "The provider is not entitled to any additional reimbursement because either the information submitted does not support the level of service or the provider's documentation lacks information to support any reimbursement."

   The requestor initially billed for the office visit with CPT code 99204, the respondent denied reimbursement for CPT code 99204. The requestor then down-coded the office visit to 99203.

   28 Texas Administrative Code §134.203(a)(5) states, "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   CPT code 99203 is defined as "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family."

   A review of the submitted documentation supports billing CPT code 99203; therefore, reimbursement is recommended.

2. The insurance carrier denied reimbursement for the x-ray, CPT code 73030-RT, based upon reason code "112-Service not furnished directly to the patient and/or not documented."

   CPT code 73030 is defined as "Radiologic examination, shoulder; complete, minimum of 2 views." The requestor appended modifier "RT-Right Side."

   A review of the submitted documentation supports the xray was documented and performed on the patient; therefore, the respondent's denial is not supported. As a result, reimbursement is recommended.

3. 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 Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2017 DWC conversion factor for this service is 57.5

The 2017 Medicare Conversion Factor is 35.8887

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77092, which is located in Houston, Texas; therefore, the Medicare participating amount is based on locality "Houston, Texas".

Using the above formula the division finds the requestor is due the following reimbursement:

CODE	MEDICARE PARTICIPATING AMOUNT	MAXIMUM ALLOWABLE REIMBURSEMENT	CARRIER PAID	AMOUNT DUE
99203	$110.67	$177.31	$0.00	$177.31
73030	$29.72	$47.62	$0.00	$47.62

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $224.93.

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 $224.93 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		07/03/2018
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.