



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 GROUP, LLP

Respondent Name

TRAVELERS INDEMNITYCO

MFDR Tracking Number

M4-18-4914-01

Carrier's Austin Representative

Box Number 05

MFDR Date Received

AUGUST 14, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are in receipt of additional payment in regards to the billed procedure 99455 V3 26 impairment rating. According to the fee guidelines we are entitled to reimbursement of \$300.00 for the injured body area as well as for the level of service billed for that day."

Amount in Dispute: \$239.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider contends they are entitled to additional reimbursement for CPT code 99455-V3 9mid-level maximum medical improvement evaluation). The Carrier has reviewed the documentation and determined the Provider was properly reimbursed. The Carrier issued reimbursement on the basis that the Provider had previously treated the Claimant, as documented by the attached DWC-73 dated 09-06-207. Therefore, reimbursement was calculated under Rule 134.250(3)(A) according to Rule 134.250(3)(B)(i). As such, reimbursement was calculated as the reimbursement for an office visit CPT code 99213. The Provider is not entitled to additional reimbursement for the disputed services."

Response Submitted By: Travelers

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: November 28, 2017, CPT Code 99455-V3-26, \$239.30, \$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 medical fee disputes.
2. 28 Texas Administrative Code §134.210, effective July 7, 2016, provides the medical fee guideline for division specific services.

3. 28 Texas Administrative Code §134.250, effective July 7, 2016, sets the reimbursement guidelines for Maximum Medical Improvement Evaluations and Impairment Rating Examinations.
4. 28 Texas Administrative Code §134.203 effective March 1, 2008, sets the reimbursement guidelines for the disputes service.
5. The disputed services were paid based upon the following reason codes:
 - P12-Workers' compensation jurisdictional fee schedule adjustment.
 - CAC-W3, 350-Additional payment made on appeal/reconsideration.
 - 298-The recommended allowance is based on the value for the professional component of the service performed.
 - 947-Upheld, no additional allowance has been recommended.

Issues

Is the requestor due additional reimbursement of \$239.30 for code 99455-V3-26?

Findings

1. The requestor is seeking medical fee dispute resolution for CPT code 99455-V3-26 in the amount of \$239.30. The respondent paid \$95.90 for the disputed service based upon "P12-Workers' compensation jurisdictional fee schedule adjustment," and "298-The recommended allowance is based on the value for the professional component of the service performed."

2. To determine if reimbursement is due the division refers to the following statute:

28 Texas Administrative Code §134.210(b)(2) states, "Modifying circumstance shall be identified by use of the appropriate modifier following the appropriate Level I (CPT codes) and Level II HCPCS codes. Where HCPCS modifiers apply, insurance carriers shall treat them in accordance with Medicare and Texas Medicaid rules. Additionally, division-specific modifiers are identified in subsection (e) of this section. When two or more modifiers are applicable to a single HCPCS code, indicate each modifier on the bill."

28 Texas Administrative Code §134.250(3) states, "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. (B) If the treating doctor refers the injured employee to another doctor for the examination and certification of MMI (and IR); and the referral examining doctor has: (i) previously been treating the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with paragraph (3)(A) of this section."

28 Texas Administrative Code §134.250 (4)(C) states, "The following applies for billing and reimbursement of an IR evaluation. (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. (i) Musculoskeletal body areas are defined as follows: (I) spine and pelvis; (II) upper extremities and hands; and (III) lower extremities (including feet)."

28 Texas Administrative Code §134.250 (4)(C)(ii)(II) states, "The MAR for musculoskeletal body areas shall be as follows: If full physical evaluation, with range of motion, is performed: (-a-) \$300 for the first musculoskeletal body area; and (-b-) \$150 for each additional musculoskeletal body area."

28 Texas Administrative Code §134.250 (4)(C)(iii) states, "If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier "WP." Reimbursement shall be 100 percent of the total MAR."

28 Texas Administrative Code §134.250 (4)(C)(iv) states, "If, in accordance with §130.1 of this title, the examining doctor performs the MMI examination and assigns the IR, but does not perform the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the examining doctor shall bill using the appropriate MMI CPT code with CPT modifier "26." Reimbursement shall be 80 percent of the total MAR."

28 Texas Administrative Code §133.307(c)(2)(M) requires "Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division. (2) Health Care Provider or Pharmacy Processing Agent Request. The requestor shall provide the

following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include: (M) a copy of all applicable medical records related to the dates of service in dispute.”

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 Medicare Conversion Factor is 35.8887

Review of Box 32 on the CMS-1500 the services were rendered in Houston, Texas.

The Medicare participating amount for code 99213 in Houston, Texas is \$74.82.

Using the above formula, the MAR is $\$119.87 \times 80\% = \95.90 . The respondent paid \$95.90.

3. The division finds the following based upon the submitted documentation and above referenced statute:
 - The requestor submitted a DWC-69 report to support billing CPT code 99455-V3-26.
 - Per 28 Texas Administrative Code §134.250 (4)(C)(iv), billing with modifier “26” results with reimbursement of 80% of total MAR.
 - For CPT code 99213-26 rendered in locality Houston, TX the total MAR is \$95.90.
 - The respondent paid \$95.90 for the MMI evaluation.
 - The DWC-69 report does not support the body areas rated and methodology to determine the impairment rating per 28 Texas Administrative Code §134.250 (4)(C)(ii)(II).
 - The requestor did not submit “a copy of all applicable medical records related to the dates of service in dispute.”
 - The dispute was not filed in the form and manner required by 28 Texas Administrative Code §133.307(c)(2)(M).
 - The requestor did not support additional reimbursement is due.

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

9/7/2018
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, effective May 31, 2012, *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 MDR 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.