Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
FONDREN ORTHOPEDIC GROUP, LLP

Respondent Name
HARTFORD INSURANCE COMPANY OF MIDWEST

MFDR Tracking Number
M4-19-1444-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
NOVEMBER 14, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "it has come to our attention that the attached claim was not processed according to the 2018 Texas fee schedule."

Amount in Dispute: $120.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Services were processed in accordance with Texas Guidelines and Fee Schedule."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 31, 2018	CPT Code 24363-80-RT	$120.68	$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, effective May 31, 2012 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 170-Reimbursement is based on the outpatient/inpatient fee schedule.
   - 18-Exact duplicate claim/service.
   - 247-A payment or denial has already been recommended for this service.
   - W3-Additional payment made on appeal/reconsideration.

- 1001-Based on the corrected billing and/or additional information/documentation now submitted by the provider. We are recommending further payment to be made for the above noted procedure code.

Issues

1. What is the applicable fee guideline for professional services?
2. Is the requestor entitled to additional reimbursement for code 24363-80-RT?

Findings

1. The fee guidelines for disputed services is found at 28 Texas Administrative Code §134.203.
2. On the disputed date of service, the requestor billed CPT codes 24363-80-RT, 24160-80-59-RT, 64708-80-59-RT. Only code 24363-80-RT is in dispute.
3. The respondent paid $377.37 for code 24363-80-RT based upon the fee guideline. The requestor is seeking additional reimbursement of $120.68.
4. 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."
5. CPT code 24363 is described as "Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)."

   The requestor appended modifier "80- Assistant Surgeon" and "RT-Right Side" to code 24363.
6. The *Medicare Claims Processing Manual* Chapter 12 §20.4.3 entitled *Assistant at Surgery Services* effective February 19, 2013, states "For assistant-at-surgery services performed by physicians, the fee schedule amount equals 16 percent of the amount otherwise applicable for the surgical payment."
7. 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 2018 DWC conversion factor for this service is 73.19.

   The Medicare Conversion Factor is 35.9996

   Review of Box 32 on the CMS-1500 the services were rendered in Houston, Texas; therefore, the locality will be based on "Houston, Texas".

   The Medicare participating amount for code 24363 in Houston, Texas is $1,525.92.

   Code 24363 is subject to multiple procedure rule (MPR) discounting of 50% of MAR.

   Using the above formula, the MAR is $3,102.31 X 50% for MPR = $1,551.16. Because the requestor billed with modifier 80 for assistant at surgery services, this amount is multiplied by 16% = $248.18 The respondent paid $377.37. The division finds the requestor is not due 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

		12/13/2018
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, 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.