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
DAVID CHEN, MD

Respondent Name
DALLAS COUNTY HOSPITAL DISTRICT

MFDR Tracking Number
M4-19-0295-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
SEPTEMBER 19, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: I had submitted a copy of Medical Guidelines from Texas Department of Insurance along with a copy of Medicare Fee allowable schedule as references in an Appeal submitted to York Risk Management on 5/15/18 but the appeal was denied with no additional payment."

Amount in Dispute: $5,748.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the carrier's position that the provider is billing for a total component but based upon the CMS, there is no amount to be charged for either the whole or technical portion of the service. The only reimbursable amount is for the professional portion. The reimbursement is based on $330.01 divided by 35.9996 multiplied by 58.3 (the DWC conversion factor) which equals $534.53. The provider was reimbursed $534.53 for each date of service. 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
January 26, 2018 January 27, 2018 January 28, 2018	CPT Code 95951 Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation (eg, for presurgical localization), each 24 hours	$1,916.10/each X 3 = $5,748.30	$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 §134.203, 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 code:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 193-Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
   - W3-Reporting purposes only.

Issues

1. What is the applicable fee guideline for professional services?
2. Is the requestor due additional reimbursement for CPT codes 95951?

Findings

1. The fee guidelines for disputed services are found in 28 Texas Administrative Code §134.203.
2. The requestor billed $3,080.00 X 3 for a total of $9,240.00 for CPT code 95951. The respondent paid $534.53 X 3 for $1,603.59. The requestor is seeking additional reimbursement of $1,916.10 X 3 = $5,748.30.

   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."

   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 58.31.

   The Medicare Conversion Factor is 35.9996

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

   The Medicare participating amount for code 95951 in Dallas, Texas is $330.01.

   Using the above formula, the MAR is $534.53. The respondent paid $534.53. As a result, the requestor is not due additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due.

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

		10/16/2018
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.