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
TEXAS COUNCIL RISK MANAGEMENT

MFDR Tracking Number
M4-19-0998-01

Carrier's Austin Representative
Box Number 43

MFDR Date Received
OCTOBER 22, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have received your payment on the claim for the above date of service. We are asking for a reconsideration base on the fact that we don't have a contract with Alliance and it states that this code should be paid $4000.00. This claim was paid incorrectly."

Amount in Dispute: $4,582.21

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Total paid on this bill is $7,398.30. This was technically due yesterday but due to the holiday the check didn't issue till today."

Response Submitted by: York Risk Services Group

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 28, 2017	CPT Code 20692-LT Application of a multiplane (pins or wires in more than 1 plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)	$2,832.21	$4.43
	CPT Code 27899-LT Unlisted procedure, leg or ankle	$1,750.00	$0.00
TOTAL		$4,582.21	$4.43

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. 28 Texas Administrative Code §134.1, provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines
5. The services in dispute were reduced/denied by the respondent with the following claims adjustment reason codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 45-Charges exceed your contracted/legislated fee arrangement.
   - 97-The benefit for this service is included in the pymnt/allowance for another service/procedure that has already been adjudicated.
   - P5-Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.
   - P14-The benefit for this service is included in the payment/allowance for another service/procedure that has been performed on the same day.
   - 59-Processed based on multiple or concurrent procedure rules.
   - W3-Additional payment made on appeal/reconsideration.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. What is the applicable fee guideline for professional services?
2. Does the documentation support the disputed services are subject to a contractual agreement?
3. Is the requestor entitled to additional reimbursement for code 20692-LT?
4. Is the requestor entitled to additional reimbursement for code 27899-LT?

Findings

1. The fee guidelines for disputed services is found at 28 Texas Administrative Code §134.203.
2. According to the submitted explanation of benefits, the respondent paid for the disputed services based upon a contractual/legislated fee arrangement. The requestor wrote "we don't have a contract with Alliance". The division finds that neither party submitted any documentation to support that the disputed services are subject to a contractual agreement; therefore, the disputed services will be reviewed per the fee guideline.
3. The requestor billed $9,000.00 for CPT code 20692-LT. The respondent paid $1,167.79. The requestor is seeking medical fee dispute resolution for an additional payment of $2,832.21.

   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."

   On the disputed date of service, the requestor billed CPT codes 27646-LT, 20692-LT, 27870-LT, 27640-LT, 28120-59-LT, 27899-LT. Only codes 20692-LT and 27899-LT are in dispute.

   28 Texas Administrative Code §134.203(b)(1) 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; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   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 72.18

The 2017 Medicare Conversion Factor is 35.8887

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 20692 in Houston, Texas is $1,165.68.

Code 20692 is subject to multiple procedure rule (MPR) discounting.

Using the above formula, the MAR is $2,344.44 X 50% = $1,172.22. The respondent paid $1,167.79. The requestor is due the difference between the amount due and paid which equals $4.43.

4. The requestor billed $1,750.00 for CPT code 27899-LT. The respondent paid $743.75. The requestor is seeking an additional reimbursement of $1,006.25.

   To determine if additional reimbursement is due for code 27899 the division refers to 28 Texas Administrative Code §134.203(f).

   28 Texas Administrative Code §134.203(f) states, "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."

   CPT code 27899 does not have a Medicare assigned relative value; therefore, the code is subject to 28 Texas Administrative Code §134.1.

   28 Texas Administrative Code §134.1(e)(3) states, " in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section."

   28 Texas Administrative Code §134.1(f)(1-3) states, "Fair and reasonable reimbursement shall:

   (1) be consistent with the criteria of Labor Code §413.011;
   (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
   (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

   28 Texas Administrative Code §133.307(c)(2)(O) requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable." Review of the submitted documentation finds that the requestor does not discuss or explain how reimbursement $1,750.00 for code 27899-LT is a fair and reasonable reimbursement. The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement. The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1. The request for additional reimbursement is not supported.

   .

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $4.43.

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 $4.43 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		01/17/2019
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.