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
TRAVELERS PROPERTY CASUALTY CO

MFDR Tracking Number
M4-19-1196-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
OCTOBER 29, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have attached the description of this code and also the authorization for the approval on this code. Please reprocess the claim and send the provider the payment we are due."

Amount in Dispute: $75.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the documentation and determined the Provider was properly reimbursed. The Carrier denied reimbursement on the basis that the code billed, CPT code 0232T, was invalid on the date of service. As an invalid codes was used, the Provider is not entitled to reimbursement for the disputed service."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 19, 2018	CPT Code 0232T	$75.88	$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 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 claim adjustment reason codes:
   - 181-Payment adjusted because this procedure code was invalid on the date of service.
   - W3-Additional payment made on appeal/reconsideration.
   - 254-The billed service has no allowance in fee schedule.

Issues

1. What is the applicable fee guideline for professional services?
2. Is the requestor entitled to reimbursement for code 0232T?

Findings

1. The fee guidelines for disputed services are found in 28 Texas Administrative Code §134.203.
2. 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."

   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."

   On the disputed date of service, the requestor billed CPT codes 99213, 99080-73 and 0232T. Only 0232T is in dispute.

   The respondent denied reimbursement because code 0232T is an invalid code on the date of service and has no allowance in the fee schedule.

   Code 0232T is described as "Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when performed." Per the AMA code 0232T is s a Category III code. Category III codes are classified as temporary codes for emerging technologies, procedures and services. CMS does not assign a fee schedule to code 0232T.

   To determine if reimbursement is due for code 0232T 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)."

   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 §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 demonstrate how reimbursement $75.88 for code 0232T 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 reimbursement is not supported.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that 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

		01/29/2019
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.