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
WAYNE O. ALANI, MD

Respondent Name
VANLINER INSURANCE CO

MFDR Tracking Number
M4-19-1707-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
NOVEMBER 26, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have received your payment on the following claim for the above date of service. We disagree with the amount paid as it appears that the code 27487 was not paid using the 2018 TX Fee Schedule."

Requestor's Supplemental Position Summary dated January 15, 2019: "We still have not received any additional payment we still have $12.75 open."

Requestor's Supplemental Position Summary dated January 16, 2019: "Yes payment was for $5026.77 which carrier paid on code 27488 $1278.85 and on code 27487 they paid $3747.92 we are short $12.75 on this code per the fee schedule. Therefore the MDR needs to stay standing."

Amount in Dispute: $12.75

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Vanliner Insurance Company shows that it paid $5,026.77. The Request for Dispute Resolution states that $3,747.92 was paid, but this is not correct. Fondren has asked only for an additional $12.75 which would already have been included in the $5,026.77 payment. Attached are copies of the Claim Check Entry form and the relevant entry in the VL WC Claim Payments history in support of this response. Vanliner requests the Division review this dispute and order no additional payment is due. "

Response Submitted by: Stone Loughlin Swanson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 26, 2018	CPT Code 27487-LT	$12.75	$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 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:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 790-The charge was reimbursed in accordance to the Texas Medical Fee Guidelines.
   - 350-Bill has been identified as a request for reconsideration or appeal.
   - W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. What is the applicable rule for determining reimbursement of the disputed services?
2. Is the requestor entitled to additional reimbursement for CPT code 27487-LT?

Findings

1. The fee guideline for Professional Care services is found in 28 Texas Administrative Code §134.203.

2. The issue in dispute is whether the requestor is due additional reimbursement of $12.75 for CPT code 27487-LT.

   28 Texas Administrative Code §134.203(b) 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…"

   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 zip code 77030, which is located in Houston, Texas; therefore, the Medicare participating amount is based on locality "Houston, Texas".

   The Medicare Participating amount for code 27487-LT in Houston, Texas is $1,843.47.

   Using the above formula, the MAR is $3,747.92. The respondent paid $3,747.92. 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 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

		1/18/2019
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, 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.