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
ORTHOTEXAS PHYSICIANS & SURGEON

Respondent Name
STANDARD FIRE INSURANCE COMPANY

MFDR Tracking Number
M4-19-1909-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
December 4, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Cortisone injections performed in an office setting do not required precertification per Rule 134.600(p)(12)."

Amount in Dispute: $413.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT 20610 is found in the surgical chapter of the AMA CPT codebook. As a surgical procedure, the service required preauthorization under Rule 134.600(p)(2) since it was performed in an outpatient setting."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
August 24, 2018	Professional Medical Services	$413.00	$211.54

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out rules regarding preauthorization of health care.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 309 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
   - 56 – SIGNIFICANT, SEPARATELY IDENTIFIABLE E/M SERVICE RENDERED
   - 199 – NUMBER OF SERVICES EXCEED UTILIZATION AGREEMENT.
   - 4924 – AN INJECTION SERVICE CODE AND A NATIONAL DRUG CODE (NDC) HAVE BEEN BILLED. THE ALLOWANCE HAS BEEN DETERMINED USING THE LISTED FEE SCHEDULE VALUE FOR THE INJECTION SERVICE CODE.

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied payment for disputed services with claim adjustment reason code:
   - 197 – PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION.

   The requestor states, "Cortisone injections performed in an office setting do not required precertification per Rule 134.600(p)(12)."

   The respondent states, "CPT 20610 is found in the surgical chapter of the AMA CPT codebook. As a surgical procedure, the service required preauthorization under Rule 134.600(p)(2) since it was performed in an outpatient setting."

   Be that as it may, Travelers has mischaracterized both the rule and the setting for the disputed services. The rule does not require preauthorization for surgeries or even outpatient surgeries. Rule §134.600(p)(2) states that non-emergency health care requiring preauthorization includes: outpatient surgical or ambulatory surgical services *as defined in subsection (a)*.

   Rule §134.600 (a)(2) defines *ambulatory surgical services* as "surgical services provided in a facility that operates primarily to provide surgical services to patients who do not require overnight hospital care."

   Rule §134.600 (a)(6) defines *outpatient surgical services* as "surgical services provided in a freestanding surgical center or a hospital outpatient department to patients who do not require overnight hospital care."

   Review of the submitted medical bill field 24B finds the place of service code listed as "11" — a medical office.

   No information was provided to support the services were provided in an ambulatory surgical center, a freestanding surgical center or a hospital outpatient department. As the rule does not list an office setting as requiring preauthorization for surgical services, and as no information was found to support preauthorization was required for other reasons, the insurance carrier's denial reason is unsupported. Consequently, the disputed services will be reviewed for reimbursement in accordance with division rules and fee guidelines.

2. This dispute regards medical services with reimbursement subject to the *Medical Fee Guideline for Professional Services*, 28 Texas Administrative Code §134.203, requiring the maximum allowable reimbursement (MAR) be determined by Medicare payment policies modified by DWC rules. The MAR is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the DWC annual conversion factor. Reimbursement is calculated as follows:
   - Procedure code 99213 has a Work RVU of 0.97 multiplied by the Work GPCI of 1 is 0.97. The practice expense RVU of 1.02 multiplied by the PE GPCI of 0.938 is 0.95676. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.796 is 0.05572. The sum is 1.98248 multiplied by the DWC conversion factor of $58.31 for a MAR of $115.60.
   - Procedure code 20610 has a Work RVU of 0.79 multiplied by the Work GPCI of 1 is 0.79. The practice expense RVU of 0.81 multiplied by the PE GPCI of 0.938 is 0.75978. The malpractice RVU of 0.12 multiplied by the malpractice GPCI of 0.796 is 0.09552. The sum is 1.6453 multiplied by the DWC conversion factor of $58.31 for a MAR of $95.94.
   - Procedure code J1040 has status indicator E — codes excluded from Medicare's Physician Fee Schedule by regulation. CMS does not determine a price or relative value. If reimbursement is justified, this code is paid at a fair and reasonable rate. Payment is subject to Rule §134.1 regarding fair and reasonable reimbursement. The insurance carrier allowed $0.00. Review of the submitted information finds insufficient information to support a different amount from that paid by the carrier; additional reimbursement is not recommended.
   - Procedure code 99080, August 24, 2018, has status indicator B, denoting a bundled code. Reimbursement is included with payment for other services to which this code is incident.

The total allowable reimbursement for the disputed services is $211.54. The insurance carrier paid $0.00. The amount due is $211.54. This amount is recommended.

Conclusion

The division emphasizes that the findings in this decision are based on the evidence presented by the requestor and respondent available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons stated above, the division finds the requestor has established that additional reimbursement is due. As a result, the amount ordered is $211.54.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $211.54, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	Date
	Grayson Richardson	January 4, 2019

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.