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
CALIFORNIA INSURANCE COMPANY

MFDR Tracking Number
M4-19-2365-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
DECEMBER 27, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have received the denial for the following codes 27645, 27646, 20680 and 11981. However, we strongly disagree with this decision."

Amount in Dispute: $7,591.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Provider seeks additional reimbursement of $7,591.56 for surgical services provided to the Claimant on June 19. 2018. Carrier properly calculated reimbursement in this case and stands by the reasons for reduction or denial of payment set forth in its Explanation of Benefits and its Response to Request for Reconsideration previously filed in this dispute. Medical documentation does not support that CPT Codes 27645 and 27646 accurately reflect the treatment rendered. Regarding CPT codes 20680 and 11981, Carrier correctly calculated and paid per the fee schedule."

Response Submitted by: Stone Loughlin Swanson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 19, 2018	CPT Code 27645	$3,515.00	$0.00
	CPT Code 27646	$3,000.00	$0.00
	CPT Code 27645-80	$486.83	$0.00
	CPT Code 27646-80	$415.50	$0.00
	CPT Code 20680-80	$124.99	$104.60
	CPT Code 11981-80	$24.62	$23.95

	CPT Code 11981-80-59	$24.62	$23.95
TOTAL		$7,591.56	$152.50

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. The services in dispute were reduced/denied by the respondent with the following claims adjustment reason codes:
   - 229-Services not identified in the operative report.
   - 509-The assistant surgeon charge is not appropriate for this service.
   - B12-Services not documented in patients medical records.
   - P12-Workers compensation jurisdictional fee schedule adjustment.

Issues

1. Does the documentation support billing codes 27645, 27646, 27645-80 and 27646-80?
2. Is the requestor entitled to reimbursement for 20680-80, 11981-80 and 11981-80-59?

Findings

1. The fee guidelines for disputed services is found at 28 Texas Administrative Code §134.203.

   According to the explanation of benefits, the respondent denied reimbursement for codes 27645, 27646, 27645-80 and 27646-80 based upon reason codes "229-Services not identified in the operative report," and "B12-Services not documented in patients medical records."

   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."

   - CPT code 27645 is defined as "Radical resection of tumor; tibia."
   - CPT code 27646 is defined as "Radical resection of tumor; fibula."
   - The 80 modifier is defined as "Assistant Surgeon."

   The Operative Report indicates "Radical resection of the distal tibia and distal fibula were performed through this anterior incision." The division finds this documentation does not support resection of tumor in the tibia or fibula; therefore, the respondent's denial of payment is supported.

2. According to the submitted explanation of benefits, the respondent denied reimbursement for codes 20680-80, 11981-80 and 11981-80-59 based upon "509-The assistant surgeon charge is not appropriate for this service".

   A review of Medicare's fee schedule allows for reimbursement of assistant surgeon charges for codes 20680 and 11981; therefore, the respondent's denial based upon reason code "509" is not supported. The division finds the requestor has supported position that reimbursement is due per the fee guideline.

   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 Houston, Texas; therefore, the locality will

be based on “Houston, Texas”.

a. The Medicare participating amount for code 20680 in Houston, Texas is $643.12.

Code 20680 is subject to multiple procedure rule (MPR) discounting of 50% of MAR.

Using the above formula, the MAR is $1,307.51 X 50% for MPR = $653.76. Because the requestor billed with modifier 80 for assistant at surgery services, this amount is multiplied by 16% = $104.60. The respondent paid $0.00. The division finds the requestor is due reimbursement of $104.60.

b. The Medicare participating amount for code 11981 in Houston, Texas is $147.26.

Code 11981 is subject to MPR discounting of 50% of MAR.

Using the above formula, the MAR is $299.39 X 50% for MPR = $149.70. Because the requestor billed with modifier 80 for assistant at surgery services, this amount is multiplied by 16% = $23.95. The respondent paid $0.00. The division finds the requestor is due reimbursement of $23.95.

c. The respondent billed for a second unit of code 11981; as stated above, the requestor is due $23.95.

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 $152.50.

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 $152.50 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	02/28/2019 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.