**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**
TEXAS HEALTH DBA INJURY 1 OF DALLAS

**Respondent Name**
PROTECTIVE INSURANCE CO

**MFDR Tracking Number**
M4-19-3901-01

**Carrier's Austin Representative**
Box Number 17

**MFDR Date Received**
APRIL 23, 2019

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The claim was paid incorrectly. CPT code 90791 was paid below PPO negotiated contract."

**Amount in Dispute:** $167.02

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Upon notification of the dispute, CorVel performed an in-depth review of the medical billing in question. CorVel determined sufficient documentation has been, provided evidencing the charge in dispute was, reduced erroneously based on units. Therefore, additional reimbursement is warranted. An immediate re-audit has been, requestor to allow supplemental reimbursement of $173.78."

**Response Submitted by:** CorVel

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| October 26, 2018 | CPT Code 90791(X5) | $167.02 | $4.94 |

## *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 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 claim adjustment reason codes:
   - P13-Payment reduced/denied based on state WC regs/policies.

- RAI-Medical Unlikely Edit; DOS exceeds MUE value.
- W3-Appeal/reconsideration.

**Issues**

1. What is the applicable fee guideline for professional services?
2. Does Medicare's Medically Unlikely Edits (MUEs) apply in this case?
3. Is the requestor entitled to additional reimbursement for CPT code 90791 (X5)?

**Findings**

1. The fee guidelines for disputed services are found in 28 Texas Administrative Code §134.203.
2. Based upon the submitted explanation of benefits, the respondent reduced payment of code 90791(X5) based upon reason code "RAI-Medical Unlikely Edit; DOS exceeds MUE value."

   On the disputed date of service, the requestor billed CPT code 90791 (X5) and 90889.

   The division reviewed the following statute to determine if the respondent's reduction of payment is supported:

   - 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."

   - 28 Texas Administrative Code §134.203(a)(7) states, "Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program."

   The disputed testing was related to a referral from a treating doctor. The division finds the respondent's reduction of payment is based upon limits of treatment/testing outlined in CMS's MUEs. These MUEs were not adopted by the division in 28 Texas Administrative Code §134.203; therefore, they do not apply in this case.

3. A review of the submitted billing and medical records finds that the requestor billed for five units of code 90791. CPT code 90791 is not defined as a timed procedure. The 2018 CPT manual indicates the code may be reported more than one per patient when a separate evaluation with an informant is performed.
   A review of the submitted documentation supports evaluation of the claimant; therefore, based on the code descriptor and the submitted report, one unit is recommended for reimbursement.

   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 58.31.

The Medicare Conversion Factor is 35.9996.

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75243 which is located in Dallas, Texas; therefore, the Medicare carrier locality is “Dallas, Texas”.

The Medicare participating amount for code 90791 is $137.16.

Using the above formula, the Division finds the MAR is $222.16. The respondent paid $217.22. The division finds the requestor is due the difference between the MAR and amount paid of $4.94.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $4.94.

## *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 $4.94 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 | 5/16/2019<br>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**.