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
MITCHELL FAGELMAN, MD

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number
M4-19-4463-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
June 11, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On this date of service, claim denied stating 'an attachment/documentation is required to adjudicate this claim/service'... See the attached documentation that supports the services provided. Please reprocess claim for payment immediately."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider has been reimbursed pursuant to the Medical Fee Guidelines."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 24, 2019	CPT Code 20611 Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	$300.00	$147.68

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, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.1, effective March 1, 2008, requires in the absence of an applicable fee guideline, medical reimbursement shall be fair and reasonable.
4. The services in dispute were reduced/denied by the respondent with the following reason code:
    - 00663-Reimbursement has been calculated according to state fee schedule guidelines.
    - 00535-An attachment/other documentation is required to adjudicate this claim/service.
    - P300-This contracted provider or hospital has agreed tor educe this charge below fee schedule or usual and customary charges for your business.
    - Z710-The charge for this procedure exceeds the fee schedule allowance.
    - P12-Workers' compensation jurisdictional fee schedule adjustment.
    - W3-Request for reconsideration.
    - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly the first time.

Issues

Is the requestor entitled to reimbursement for CPT code 20611 rendered on January 24, 2019?

Findings

The fee guidelines for disputed service is found in 28 Texas Administrative Code §134.203.

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…"

The respondent denied reimbursement for code 20611-RT based upon the fee guideline.

Per the *National Correct Coding Initiative Edits Manual* Chapter 4, (H), (7), effective January 1, 2019, "CPT codes 20600-20611 are a family of codes describing arthrocentesis for aspiration and/or injection of different sized joints or bursae with or without ultrasound guidance. The unit of service (UOS) for each of these codes is a joint and its surrounding bursae, if any. A physician shall not report more than one (1) UOS for arthrocentesis of any one joint regardless of whether or not the physician also aspirates or injects one or more of its surrounding bursae. For example, if a physician performs arthrocentesis of the shoulder and two bursae of the same shoulder without ultrasound guidance, only 1 UOS of CPT code 20610 may be reported."

The requestor submitted a report that supports the billed service; therefore, reimbursement is recommended.

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).

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75010, which is located in Carrollton, Texas; therefore, the Medicare participating amount is based on locality "Rest of Texas".

Place of Service is 11.

The 2019 DWC conversion factor for this service is 59.19.

The 2018 Medicare Conversion Factor is 36.0391

The Medicare participating amount for this location is $89.92.

Using the above formula, the division finds the MAR is $147.68. The respondent paid $0.00. The requestor is due the difference between MAR and amount paid of $147.68.

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 $147.68.

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 $147.68 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		07/11/2019
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.