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 PHYSCIANS AND SURGEONS

Respondent Name
ACE AMERICAN INSURANCE CO

Carrier's Austin Representative
Box Number 15

MFDR Tracking Number
M4-20-1138-01

MFDR Date Received
JANUARY 6, 2020

REQUESTOR'S POSITION SUMMARY

"On this date of service, this claim was originally submitted with CPT 99204 in error. This has been changed to 99203. Please see the attached documentation as support of the corrected claim."

Amount in Dispute: $454.00

RESPONDENT'S POSITION SUMMARY

The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 27, 2019	CPT Code 99203	$300.00	$173.37
	CPT Code 73564-LT	$104.00	$65.60
	CPT Code A9999	$50.00	$0.00
TOTAL		$454.00	$238.97

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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203, effective March 1, 2008, sets the reimbursement guidelines for professional services.

3. 28 TAC §134.1, effective March 1, 2008 requires in the absence of a fee guideline or medical contract, reimbursement for services shall be fair and reasonable.
4. Texas Labor Code §413.011 requires the fee guidelines to be fair and reasonable.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 00663-Reimbursement has been calculated according to state fee schedule guidelines.
   - 00084-(16)-Claim/service lacks information or has submission/billing error(s).
   - 00391-(181)-Procedure code was invalid on the date of service.
   - 00086-18)-Exact duplicate claim/service.

Issues

Is the requestor entitled to reimbursement for CPT codes 99203, 73564, and A9999 rendered on August 27, 2019?

Findings

1. The Austin carrier representative for Ace American Insurance Co is Downs Stanford, PC. Downs Stanford, PC acknowledged receipt of the copy of this medical fee dispute on January 14, 2020. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information
   As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).
2. The requestor is seeking medical fee dispute resolution in the amount of $454.00 for CPT codes 99203, 73564, and A9999 rendered on August 27, 2019.
3. The respondent denied reimbursement for the disputed services based upon "00084-(16)-Claim/service lacks information or has submission/billing error(s).
4. The fee guidelines for professional services are found in 28 TAC §134.203.
5. The disputed services are described as:
   - 99203-Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
   - 75364-Radiologic examination, knee; complete, 4 or more views.
   - A9999-Miscellaneous DME supply or accessory, not otherwise specified.
6. Dr. Kevin R. Myers report supports billing the disputed services; therefore, the respondent's denial of payment is not supported. The DWC finds the requestor is due reimbursement per medical fee guideline.
7. The fee guideline for codes 99203 and 75364 is found at 28 TAC §134.203(c)(1)(2), which states:

   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 2019 DWC conversion factor for this service is 59.19.

The Medicare Conversion Factor is 36.0391.

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 will be based on the reimbursement for "Rest of Texas".

Using the above formula, the DWC finds the MAR is:

CPT Codes	Medicare Participating Amount	MAR	Carrier Paid	Total Amount Due
99203	$105.56	$173.37	$0.00	$173.37
73564	$39.94	$65.60	$0.00	$65.60

8. The fee guideline for code A9999 is found at 28 TAC §134.203(d)(1)(2) which states, "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:
   (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule.
   (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS.
   (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.

   A review of the DMEPOS and Texas Medicaid fee schedule finds no fee schedule assigned to code A9999; therefore, 28 TAC §134.203(f) applies to this code.

9. 28 TAC §134.203(f) states, " For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."

10. 28 TAC §134.1(e)(3) states, " in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section."

11. 28 TAC §134.1(f)(1-3) states, "Fair and reasonable reimbursement shall:
   (1) be consistent with the criteria of Labor Code §413.011;
   (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
   (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

12. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It

further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

13. 28 TAC §133.307(c)(2)(O) requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable." Review of the submitted documentation finds that the requestor does not discuss or explain how reimbursement of $50.00 for code A9999 is a fair and reasonable reimbursement. The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement. The requestor did not support that payment of the requested amount would satisfy the requirements of 28 TAC §134.1. The request for reimbursement is not supported.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $238.97.

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 DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of $238.97 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		02/27/2020
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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **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.