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
ORTHOTEXAS PHYSICIANS AND SURGEONS

Respondent Name
OLD REPUBLIC INSURANCE CO

MFDR Tracking Number
M4-20-2410-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
JUNE 4, 2020

REQUESTOR'S POSITION SUMMARY

"Nowhere in CMS guidelines, Medicare CCI edits or AAOS does CPT code 20900 bundle with CPT code 28208. See the attached documentation that supports the services provided."

Amount in Dispute: $1,588.00

RESPONDENT'S POSITION SUMMARY

"Supplemental response will be provided once the bill auditing company has finalized their review."

Response Submitted by: Gallagher Bassett Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 4, 2019	CPT Code 28730	$0.00	$0.00
	CPT Code 27691	$0.00	$0.00
	CPT Code 28208	$0.00	$0.00
	CPT Code 20900	$1,588.00	$412.56
TOTAL		$1,588.00	$412.56

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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2012 sets out the procedures for resolving a medical fee dispute.
2. 28 TAC §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 reason codes:
   - 00663-Reimbursement has been calculated according to state fee schedule guidelines.
   - 00136-96-Non-covered charge.
   - W3-Request for reconsideration.

Issues

Is the requestor entitled to additional reimbursement for CPT code 20900 rendered on December 4, 2019?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $1,588.00 for CPT code 20900 rendered on December 4, 2019.
2. The respondent denied reimbursement for CPT code 20900 based upon "Non-covered charge."
   28 TAC §133.307(d)(2)(H) requires the respondent to "If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements)." A review of the submitted documentation finds the respondent did not file any Plain Language Notices to support the denial; therefore, the disputed service will be reviewed per the medical fee guideline.
3. The fee guidelines for disputed services is found at 28 TAC §134.203.
4. 28 TAC §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."
5. 28 TAC §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."
6. CPT code 20900 is described as "Bone graft, any donor area; minor or small (eg, dowel or button)."
7. Review of the Operative Report supports billed service; therefore, the insurance carrier's denial of payment is not supported.
8. 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 DWC had been using this MEI annual percentage adjustment: The 2006 DWC 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) DWC conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

   The 2019 DWC Conversion Factor is 74.29

   The 2019 Medicare Conversion Factor is 36.0391

   Per the CMs 1500, the services were rendered in Plano, TX; therefore, the Medicare locality is "Rest of Texas".

   Medicare Participating Amount at this locality is $400.28.

   Using the above formula, the DWC finds the MAR is $825.13; however, this code is subject to multiple

procedure reduction of 50% = $412.56. The respondent paid $0.00. The requestor is due $412.56.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $412.56.

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 $412.56, 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	08/06/2020 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 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 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 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.