TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
ORTHOTEXAS PHYSICIANS AND SURGEONS

**Respondent Name**
MASSACHUSETTS BAY INSURANCE CO

**MFDR Tracking Number**
M4-21-0480-01

**Carrier's Austin Representative**
Box Number 01

**MFDR Date Received**
NOVEMBER 19, 2020

## *REQUESTOR'S POSITION SUMMARY*

"On this date of service, visit on the same day as a procedure is not allowed.' New patient evaluation is required for Dr. Myers to know that the injection performed was required. Modifier 25 was used with CPT 99204 to show that this was a significant separate eval on the same day as a procedure. See the attached dictation that supports the services rendered. Please process this claim for payment immediately."

**Amount in Dispute:** $450.00

## *RESPONDENT'S POSITION SUMMARY*

"The provider submitted a dispute based on no payment for CPT code 99204 in the amount of $450.00. We processed the original bill on 7/30/2020 and allowed a payment of $263.95. Subsequently our office received a reconsideration which was processed on 11/04/2020 at which time based on the submitted documentation we found that the report did not substantiate the level of service billed due to 'Medical decision making does not meet the criteria to quality for moderation complexity.'"

**Response Submitted By:** Medata

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| July 1, 2020 | CPT Code 99204-25<br>Office Visit | $450.00 | $268.84 |
| | CPT Code 20610<br>Arthrocentesis | $0.00 | $0.00 |
| | CPT Code 73564<br>Xray Knee | $0.00 | $0.00 |

| | | | |
|---|---|---|---|
| July 1, 2020 | CPT Code 73030<br>Xray Shoulder | $0.00 | $0.00 |
| | HCPCS Code J1100<br>Injection | $0.00 | $0.00 |
| TOTAL | | $450.00 | $268.84 |

## *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 §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 the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason code:
    - P12-Workers' compensation jurisdictional fee schedule adjustment.
    - The benefit for this service is included in the payment/allowance for another service/procedure that has been performed on the same day.
    - B13-Previously paid Payment for this claim/service may have been provided in a previous payment.
    - 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 99204-25 rendered on July 1, 2020?

**Findings**

The requestor is seeking medical dispute resolution in the amount of $450.00 for CPT code 99204-25 rendered on July 1, 2020.

The respondent denied reimbursement for code 99204-25 based upon the fee guideline.

The fee guidelines for disputed service is found in 28 TAC §134.203.

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

Per 28 TAC §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 2020 DWC conversion factor for this service is 60.32.

The 2020 Medicare Conversion Factor is 36.0896

The Medicare participating amount for this location is $160.85.

Using the above formula, the DWC finds the MAR is $268.84. The respondent paid $0.00. The requestor is due the difference between MAR and amount paid of $268.84.

**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 $268.84.

***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 $268.84 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| | | |
|---|---|---|
| | | 12/16/2020 |
| 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**.