



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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

ORTHOTEXAS PHYSICIANS AND SURGEONS

Respondent Name

AMTRUST INSURANCE CO OF KANSAS INC

MFDR Tracking Number

M4-21-0518-01

Carrier's Austin Representative

Box Number 17

MFDR Date Received

NOVEMBER 20, 2020

REQUESTOR'S POSITION SUMMARY

The requestor did not submit a position summary.

Amount in Dispute: \$500.00

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 |
|------------------|---|-------------------|------------|
| July 11, 2020 | Professional Services for CPT Code 62323 Provided in a Facility | \$500.00 | \$208.75 |

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, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. Neither party to the dispute submitted any explanation of benefits to support the denial of payment for CPT code 62323. The requestor supported the bill was submitted to the respondent for payment.

Issues

Is the requestor entitled to reimbursement for CPT code 62323 rendered on July 11, 2020?

Findings

1. The Austin carrier representative for Amtrust Insurance Co of Kansas Inc is Downs Stanford, PC. Downs Stanford, PC received a copy of this medical fee dispute on December 1, 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 dispute resolution in the amount of \$500.00 for CPT code 62323 rendered on July 11, 2020.
3. Because explanation of benefits were not submitted to support the denial of payment, the DWC will review the disputed service per the fee guideline.
4. 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.

5. 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 75093, which is located in Plano, Texas; therefore, the Medicare participating amount is based on locality "Rest of Texas".

Place of Service is 24.

The 2020 DWC conversion factor for this service is 75.7.

The 2020 Medicare Conversion Factor is 36.0896

The Medicare participating amount for this location is \$99.52.

Using the above formula, the DWC finds the MAR is \$208.75. The respondent paid \$0.00. The requestor is due the difference between MAR and amount paid of \$208.75.

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 \$208.75.

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 \$208.75 plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this Order.

Authorized Signature

| | | |
|-----------|--|------------|
| | | 02/11/2021 |
| 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 TAC §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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.