



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

JACK L. DEETJEN, MD

Respondent Name

OLD REPUBLIC INSURANCE CO

MFDR Tracking Number

M4-21-0847-01

Carrier's Austin Representative

Box Number 44

MFDR Date Received

JANUARY 28, 2021

REQUESTOR'S POSITION SUMMARY

"You have denied part of this claim and paid part of it incorrectly. According to the Texas Workers Compensation fee guidelines these codes are payable at Medicare's allowable times 123%."

Amount in Dispute: \$1,133.97

RESPONDENT'S POSITION SUMMARY

"Attached is a copy of all bills received to date, and their corresponding EOB's and payment details."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|-------------------|----------------------|-------------------|------------|
| November 18, 2020 | CPT Code 29877-RT-59 | \$1,133.97 | \$0.00 |
| | CPT Code 29881-RT | | \$848.59 |
| TOTAL | | \$1,133.97 | \$848.59 |

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:
 - P12-Workers' compensation jurisdictional fee schedule adjustment.
 - 231-Mutually exclusive procedures cannot be done is the same day/setting.
 - 223-Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.
 - 573-A carrier self-assessed late fee was added to the fee schedule allowance when properly submitted bill is not paid within bill review state's mandated required number of days for a compensation injury.
 - 6176-Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting.
 - 6190-In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor) component codes of comprehensive surgery: Musculoskeletal system procedure (20000-29999) has been disallowed.
 - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to additional reimbursement for CPT codes 29877 and 29881 rendered on November 18, 2020?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of \$1,133.97 for CPT codes 29877 and 29881 rendered on November 18, 2020.
2. To determine if the disputed services are eligible for additional reimbursement the DWC refers to the following statute:
 - 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."
 - 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."
3. The disputed services are described as:
 - 29877- Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty).
 - 29881- Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed.
4. CPT code 29877:

The respondent denied reimbursement for CPT code 29877 based upon reason codes "231," and "6190." (code description listed above)

Per CCI edits, CPT code 29877 is inclusive to code 29881 and is not separately billable; therefore, the respondent's denial of payment is supported.
5. CPT code 29881:

The respondent paid \$271.48 for CPT code 29881 based upon the fee guideline.

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 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 2020 DWC Conversion Factor is 75.70

The 2020 Medicare Conversion Factor is 36.0896

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

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

| Code | Medicare Participating Amount | MAR | Insurance Carrier Paid | Amount Due |
|-------|-------------------------------|------------|------------------------|------------|
| 29881 | \$533.99 | \$1,120.07 | \$271.48 | \$848.59 |

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 \$848.59.

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 \$848.59, 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

Date

03/23/2021

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.