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
GRANT DONALD GILLILAND MD

Respondent Name
CITY OF IRVING

MFDR Tracking Number
M4-21-1359-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
April 6, 2021

Response Submitted by:
WHITE ESPEY PLLC

REQUESTOR'S POSITION SUMMARY

"Discussed case with patients workman's comp insurance company. They agreed to pay a discounted rate of $21,000 for… surgery within 7 days of receipt of his surgery. If not paid within 7 days they agree to pay the entire balance plus collection and attorney fees."

RESPONDENT'S POSITION SUMMARY

"Respondent denies that any agreement existed that it would pay more than the applicable fee guidelines for the services on October 21, 2020. Respondent did not agree, verbally or in writing, to pay more than the applicable fee guidelines. Provider's assertion that such an agreement existed is either mistaken or false. All amounts owed pursuant to the applicable fee guidelines for the services at issue, have been paid. No agreement exists or existed to pay more than the applicable fee guidelines."

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
October 21, 2020	65105, 68326, 67400, 67343, 67036 and 67500	$15,460.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code (TLC) §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 §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 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
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 59 – Processed based on multiple or concurrent procedure rules.
   - P12 – Workers compensation jurisdictional fee schedule adjustment.

Issue(s)

1. What are the denial reasons for the services in dispute?
2. Are the services in dispute subject to the multiple surgery reduction procedure?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor seeks reimbursement for professional services October 21, 2020. The insurance carrier denied/reduced the disputed service(s) with denial reduction code(s), 59 and P12 (descriptions provided above.)

   The insurance carrier states, "All amounts owed pursuant to the applicable fee guidelines for the services at issue, have been paid."

2. The services in dispute are, CPT Codes 65105, 68326, 67400, 67343, 67036 and 67500 rendered on October 21, 2020.

   28 TAC §134.203 (b) states in pertinent part, "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."

   Review of the Medicare Claims Processing Manual, Chapter 12, 40.6, Claims for Multiple Surgeries defines multiple surgeries as "…separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed. Co-surgeons, surgical teams, or assistants-at-surgery may participate in performing multiple surgeries on the same patient on the same day."

   It further states that reimbursement is determined "Base payment for each ranked procedure (indicator '2') on the lower of the billed amount, or:
   - 100 percent of the fee schedule amount for the highest valued procedure;
   - 50 percent of the fee schedule amount for the second through the fifth highest valued procedure."

   The CPT Codes are defined as follows:
   - 67343 – Release of extensive scar tissue without detaching extraocular muscle (separate procedure)
     This code contains a surgery indicator "2"
     This code is the highest valued procedure and is reimbursed at 100% of the MAR.
   - 65105 – Enucleation of eye; with implant, muscles attached to implant
     This code contains a surgery indicator "2"
     This code is subject to the multiple procedure rule discounting of 50%.
   - 68326 – Conjunctivoplasty, reconstruction cul-de-sac; with conjunctival graft or extensive rearrangement
     This code contains a surgery indicator "2"
     This code is subject to the multiple procedure rule discounting of 50%.
   - 67400 – Orbitotomy without bone flap (frontal or transconjunctival approach); for exploration, with or without biopsy
     This code contains a surgery indicator "2"
     This code is subject to the multiple procedure rule discounting of 50%.
   - 67036 – Vitrectomy, mechanical, pars plana approach;
     This code contains a surgery indicator "2"
     This code is subject to the multiple procedure rule discounting of 50%.
   - 67500 – Retrobulbar injection; medication (separate procedure, does not include supply of medication)
     This code contains a surgery indicator "2"
     This code is subject to the multiple procedure rule discounting of 50%.

3. 28 TAC §134.203 states in pertinent part, "(c) 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..."

   Using the formula indicated in 28 TAC 134.203 (c) and the Medicare Claims Processing Manual, Chapter 12, 40.6, Claims for Multiple Surgeries reimbursement is calculated below:

   - 67343 – This code contains a surgery indicator "2"
     This code is the highest valued procedure and is reimbursed at 100% of the MAR.
     The MAR $2,126.90
   - 65105 – This code contains a surgery indicator "2"
     This code is subject to the multiple procedure rule discounting of 50%.
     The MAR is $975.61
   - 68326 – This code contains a surgery indicator "2"
     This code is subject to the multiple procedure rule discounting of 50%.
     The MAR is $968.89
   - 67400 – This code contains a surgery indicator "2"
     This code is subject to the multiple procedure rule discounting of 50%.
     The MAR is $708.66
   - 67036 – This code contains a surgery indicator "2"
     This code is subject to the multiple procedure rule discounting of 50%.
     The MAR is $694.13
   - 67500 – This code contains a surgery indicator "2"
     This code is subject to the multiple procedure rule discounting of 50%.
     The MAR is $65.85

   The total recommended amount is $5,540.04. The insurance carrier issued a payment in the amount of $5,540.00. Therefore, the requestor is not entitled to additional reimbursement for the services in dispute.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of TLC §413.031, the DWC has determined that the requestor is not entitled to reimbursement for the disputed services.

Authorized Signature

		May 21, 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).