

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Jason R. Bailey, M.D.

Respondent Name

ACE American Insurance Company

MFDR Tracking Number

M4-22-0662-01

Carrier's Austin Representative

Box Number 15

DWC Date Received

December 3, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 25, 2021	Surgical Services CPT 13152	\$3,172.99	\$0.00

Requestor's Position

Our physician, Dr. Rose, has been grossly under-reimbursed for a medically necessary emergent surgery ... at just under 18.5% of billed charges.

Amount in Dispute: \$3,172.99

Respondent's Position

ESIS Med Bill Impact's Bill Review Department reviewed the above mentioned date of service and found that the provider was not due additional money. It has been determined that ESIS Med Bill Impact will stand on the original recommendation of \$718.01.

Response Submitted by: ESIS

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the fee guidelines for professional services.

Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- 16 – Claim/service lacks information or ahas submission/billing error(s) which is needed for adjudication.
- Note: "Bill is denied; invalid/missing healthcare provider license number Please re-submit with appropriate license number for review."
- Note: "Bill is denied, invalid/missing billing provider license number. Please re-submit with appropriate license number for review."
- Note: "Bill is denied; invalid/missing rendering provider license number. Please re-submit with appropriate license number for review."
- Note: "Charge exceeds Fee Schedule allowance"
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- Note: "Previous gross recommended payment amount on line: \$0; Previous recommended payment amount on this line: \$0, Additional recommended allowance of \$718.01 is being made based upon additional supporting documentation received"
- Note: "Additional recommendation is based upon additional supporting documentation received."
- Note: "A technical Bill Review (TBR) has been performed."
- W3 – TDI Level 1 Appeal means a request for reconsideration under 133.250 of this title or an appeal of an adverse determination under Chapter 19, Subchapter U of this title."

Issues

1. Is Jason R. Bailey, M.D. entitled to additional reimbursement?

Findings

1. Dr. Bailey is seeking additional payment of \$3,172.99 for surgical services performed on June 25, 2021. Per explanation of benefits dated November 15, 2021, ACE American Insurance Company paid \$718.01.

Reimbursement for physician reimbursement for the service in question is subject to 28 TAC §134.203.

28 TAC §134.203(c) states,

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.
- (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 place of service for the service in dispute was identified using code 21. Code 21 indicates that the service was performed in a facility setting. The documentation provided supports that services were provided in a facility setting.

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

- The DWC conversion factor in a facility setting for 2021 is 76.76.
- The Medicare conversion factor for 2021 is 34.8931.
- Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 77304 which is located in Conroe, Texas; therefore, the Medicare locality is "Rest of Texas."
- The Medicare participating amount for CPT code 13152 at this locality is \$326.39.

Using the above formula, the MAR is \$718.01 for CPT code 13152. The insurance carrier paid \$718.01. No additional reimbursement is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requestor has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not

entitled to additional reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

February 17, 2022

Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico CompConnection@tdi.texas.gov.