Division of Workers' Compensation

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Medical Fee Dis+pute Resolution Findings and Decision

General Information

Requestor Name
UT Physicians

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-22-2479-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
July 25, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 22, 2022	23430/29823/23550/ 23120	$12,284.00	$5,048.47
	Total	$12,284.00	$5,048.47

Requestor's Position

The requestor did not submit a position statement with this request for MFDR.

Amount in Dispute: $12,284.00

Respondent's Position

"To resolve this fee reimbursement dispute, Texas Mutual has elected to reprocess the disputed services in accordance with the appropriate Medical Fee Guideline as defined per Texas Administrative Code Rule 134 – Guidelines for Medical Services, Charges and Payments. This does not guarantee payment, however the surgeons bills were received after the appeal of the assistant surgeon…"

<u>Response submitted by:</u> Texas Mutual

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 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the fee guidelines for professional services.
3. Texas Insurance Code (TIC) 1451.104 allows for different reimbursement for medical doctors and physician assistants

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- P12 – Workers' compensation jurisdiction fee schedule adjustment
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 892 – Denied in accordance with DWC Rules and/or medical fee guideline including current CPT code descriptions/instructions
- 892 – Surgeons bill has not bee received. Codes must match

Issues

1. Is the insurance carrier's denial supported?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for physician assistant at surgery services rendered in March of 2022. The insurance carrier denied the services as 802 – "Surgeons bill has not been received, codes must match."

   DWC Rule 134.203 (b) (1) states in pertinent part or coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply Medicare payment policies, including its coding and billing.

   Review of the Medicare payment policy found at www.cms.gov , Chapter 12, Section 110.2 found

no such requirement. This requirement was not found in Division Rule 134.203.

The insurance carrier's denial is not supported. The disputed charges will be reviewed per applicable fee guideline.

2. Texas Insurance Code Sec. 1451.104 states in part:

   (c) Notwithstanding Subsection (a), a health insurance policy may provide for a different amount of payment or reimbursement for scheduled services or procedures performed by an advanced practice nurse, nurse first assistant, licensed surgical assistant, or physician assistant if the methodology used to compute the amount is the same as the methodology used to compute the amount of payment or reimbursement when the services or procedures are provided by a physician.

   This provision allows insurance carriers to reimburse physician assistants at a different amount than physicians.

   DWC Rule 28 TAC §134.203 Medical Fee Guideline for Professional Services, states:

   (a) (5) "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.

   (b) 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.

   Chapter 12 of the Medicare Claims Processing Manual states, Physician Assistants
   (Rev. 2656, Issuance: 02-07-13, Effective: 02-19-13, Implementation: 02-19-13)
   Medicare law at section 1833(a)(1)(O) of the Social Security Act authorizes payment for services that a PA furnishes as an assistant-at-surgery. Specifically, when a PA actively assists a physician in performing a surgical procedure and furnishes more than just ancillary services, the PA's services are eligible for payment as assistant-at-surgery services.

   The A/B MAC (B) shall pay covered PA assistant-at-surgery services at 80 percent of the lesser of the actual charge or 85 percent of what a physician is paid under the Medicare Physician Fee Schedule.

   TIC 1451.04(c) allows the insurance carrier to pay a PA a different amount if the "methodology used to compute the amount is the same as the methodology used to compute the amount of payment or reimbursement when the services or procedures are provided by a physician." A physician is paid at the Medicare rate plus a DWC multiplier. Reimbursing a PA at 80 percent of the actual charge is not the same methodology used for physician reimbursement and is

contrary TIC 1451.04(c).
The DWC finds that the requestor is therefore entitled to 85% of the Medicare Physician Fee Schedule.

3. DWC Rule 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... (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..."

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

   The 2022 DWC conversion factor is 78.37.

   The Medicare conversion factor is 34.6062

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 77030, located in Houston, Texas; The Medicare participating amount is based on locality "Houston, Texas".

   The maximum allowable reimbursement (MAR) is as follows:

Billed Code	Medicare Physician Fee Schedule Amount	DWC Conversion Factor/Medicare Conversion Factor 78.37/34.6062 x MPFS Amount	Maximum Allowable Reimbursement	MAR multiplied by 85%
23120	$617.64	$1,398.72	$1,398.72	$1,188.47
23430	$781.20	$1,769.12	$1,769.12	$1,503.75
23550	$602.09	$1,363.51	$1,363.51	$1,158.98
29823	$621.98	$1,408.55	$1,408.55	$1,197.27
		Total	$5,939.90	$5,048.47

3. The total allowed amount is $5,048.47. This amount is recommended

<u>Conclusion</u>

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 requester has established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that respondent must remit to requestor $5,048.47 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 13, 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 electronico CompConnection@tdi.texas.gov.