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 and Address

CARL CANNON MD
SUITE 300
1441 WOODSTEAD COURT
WOODLANDS TX 77380

Respondent Name
STANDARD FIRE INSURANCE CO

Carrier's Austin Representative
Box Number 05

MFDR Tracking Number
M4-13-1676-01

MFDR Date Received
March 4, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We contacted the adjuster, Ms. Carlotta Holmes who informed me that the patient underwent a peer review with Dr. Mark McElhannon, M.D. on 10-19-12. She states that the surgery is being denied because the peer physician did not agree that the proposed left knee surgery would be reasonable and necessary at this time... Prior to the knee arthroscopy for the partial medial meniscectomy, it was submitted for precertification. We received approval with reference #JV40."

Amount in Dispute: $2,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines. Any re-audit EOBs will be supplemented."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 29, 2012	29881	$2,000.00	$1,048.05

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.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline procedures for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out the Preauthorization, Concurrent Review, and Voluntary Certification of Health Care.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment
   - PI – There are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not reasonable or necessary. The amount adjusted is generally not the patients responsibility, unless the workers compensation state law allows the patient to be billed

Issues

1. Did the insurance carrier submit documentation to support that a previous payment was issued for CPT code 29881 rendered on October 29, 2012?
2. Did the requestor obtain preauthorization for the disputed CPT code 29881?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.307 states in pertinent part, "(d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division. (2) Response. Upon receipt of the request, the respondent shall provide any missing information not provided by the requestor and known to the respondent. The respondent shall also provide the following information and records... (B) a paper copy of all initial and appeal EOBs related to the dispute, as originally submitted to the health care provider in accordance with this chapter, related to the health care in dispute not submitted by the requestor or a statement certifying that the respondent did not receive the health care provider's disputed billing prior to the dispute request..."

   The insurance carrier reduced/denied disputed CPT code 29881, with denial/reduction code "B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment." Review of the submitted documentation provided by both parties does not contain a copy of an EOB in support that a previous payment was made for disputed CPT code 29881. As a result, the disputed CPT code 29881 will be reviewed pursuant to 28 Texas Administrative Code §134.600.
2. Per 28 Texas Administrative Code §134.600 "(p) Non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay; (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section..."

   Review of the preauthorization letter issued by Sedgwick CMS, dated October 22, 2012 indicates that preauthorization was obtained for CPT code 29881, knee arthroscopy/surgery, reference # JV40 and approved with a start date of October 22, 2012 and an end date of December 7, 2012. As a result, the disputed service was preauthorized and will be reviewed pursuant to 28 Texas Administrative Code §134.203.
3. Per 28 Texas Administrative Code §134.203 "(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."

   Per 28 Texas Administrative Code §134.203 "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

   The MAR reimbursement for CPT code 29881 rendered in "Rest of Texas" is $1,048.05. Therefore, this amount is recommended to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,048.05.

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 Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,048.05 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		January 16, 2014
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 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 Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division 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 Division. **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).