



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Collom and Carney Orthopedics

Respondent Name

State Office of Risk Management

MFDR Tracking Number

M4-15-1100-01

Carrier's Austin Representative

Box Number 45

MFDR Date Received

December 9, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "[The injured employee] WAS A NEW PATIENT TO THE ORTHOPEDICS DEPARTMENT. HE WAS REFERRED BY DR. CHERYL CLEVINGER, FAMILY PRACTICE, TO SEE BRYAN SPRUILL P.A., WHO IS A PHYSICIAN ASSISTANT TO DR. DARIUS MITCHELL."

Amount in Dispute: \$138.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Although a physician assistant may bill for 'new patient' services, they can only bill for new patient services when they are billing under their own provider billing number, however in this case Mr. Spruill billed utilizing the Clinic's billing number in which is the same billing number utilized by Dr. Cheryl Clevenger MD."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: July 7, 2014, Initial Office Visit (99202), \$138.00, \$74.92

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
• 886 – The procedure was inappropriately billed. The provider has previously billed for an initial/evaluation visit.

- B16 – Payment adjusted because ‘new patient’ qualifications were not met.
- 247 – A payment or denial has already been recommended for this service
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.

Issues

1. Are the insurance carrier’s reasons for denial of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Collum and Carney Orthopedics is seeking reimbursement for an initial office visit performed by Bryan Spruill, P.A. on July 7, 2014. The insurance carrier denied that service stating that the provider previously billed for an initial visit and that new patient qualifications were not met.

Coding, billing, and reimbursement of professional medical services are based on Medicare payment policies in effect on the date of service.¹ Medicare states that “Physicians in the same group practice but who are in different specialties **may bill and be paid without regard to their membership in the same group** [emphasis added].”²

Medicare defines a new patient as “a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (**same physician specialty**) [emphasis added] within the previous 3 years.”³

Documentation submitted to the division finds that a bill received by the State Office of Risk Management on September 22, 2014, was billed using the NPI and license number for Bryan Spruill, PA-C as the rendering provider. On the date of service, documentation indicates that Mr. Spruill was a physician assistant to Dr. Darius Mitchell, an orthopedic surgeon.

No documentation was provided to support that the injured employee was seen by Mr. Spruill, Dr. Mitchell, or another physician of the same specialty within the previous three years prior to the disputed service. Therefore, the division concludes that the insurance carrier’s denial is not supported.

2. Because the insurance carrier’s denial of payment was not supported, the requestor is eligible for reimbursement.

Reimbursement for the testing in question is based on Medicare policies using the conversion factor determined by the division for the appropriate year.⁴ The conversion factor for 2014 is \$55.75.⁵ “Physician assistant services are paid 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.”⁶

The actual charge for this service by the requestor is \$138.00. The physician reimbursement for the service in question is \$110.18 and 85 percent of this fee is \$93.65. The lesser of the two is \$93.65 and 80 percent of this fee is \$74.92. This amount is recommended.

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 \$74.92.

¹ 28 Texas Administrative Code §134.203(b)

² Medicare Claims Processing Manual, Chapter 12 §30.6.5

³ Medicare Claims Processing Manual, Chapter 12 §30.6.7

⁴ 28 Texas Administrative Code §134.203(b) and (c)

⁵ <https://www.tdi.texas.gov/bulletins/2018/documents/001718table.pdf#CY2019> Table of Conversion Factors

⁶ Medicare Claims Processing Manual, Chapter 12 §110

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 \$74.92, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

_____	_____ Laurie Garnes _____	_____ March 13, 2019 _____
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 Rule §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 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. **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.