



# 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**

ORTHOPAEDIC ASSOCIATES OF CENTRAL TX

**Respondent Name**

ACE AMERICAN INSURANCE CO

**MFDR Tracking Number**

M4-17-1120-01

**Carrier's Austin Representative**

Box Number 15

**MFDR Date Received**

DECEMBER 27, 2016

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Please review this claim that has not been paid by Gallagher Bassett."

**Amount in Dispute:** \$4,645.32

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Our bill audit company has determined additional monies are owed in the amount of \$1947.71."

**Response Submitted By:** Gallagher Bassett

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 22, 2016	CPT Code 64910	\$2354.79	\$215.22
	CPT Code 20103	\$1678.68	
	CPT Code 69990	\$611.85	\$0.00
TOTAL		\$4,645.32	\$215.22

#### 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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
- 28 Texas Administrative Code §134.1, effective March 1, 2008, requires in the absence of an applicable fee guideline, medical reimbursement shall be fair and reasonable.
- The services in dispute were reduced/denied by the respondent with the following reason code:
  - P300-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

- 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- P12-Workers' compensation jurisdictional fee schedule adjustment.
- W3-Additional payment made on appeal/reconsideration.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly the first time.

## Issues

1. Is the allowance of code 69990 included in the allowance of another procedure performed on the disputed date of service? Is the requestor entitled to reimbursement?
2. Is the requestor entitled to additional reimbursement?

## Findings

1. On the disputed date of service the requestor billed codes 64910, 20103 and 69990. The respondent denied reimbursement for code 69990 based upon "97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

28 Texas Administrative Code §134.203(b) states "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..."

Per CCI edits, code 69990 has a conflict with 64910 and should not be billed together; therefore, reimbursement is not recommended.

2. The disputed issue is whether the requestor is due additional reimbursement per 28 Texas Administrative Code §134.203 for codes 64910 and 20103.

Per 28 Texas Administrative Code §134.203(c)(1)(2), "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. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

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

The 2016 DWC conversion factor for this service is 71.32.

The Medicare Conversion Factor is 35.8043

Review of Box 32 on the CMS-1500 the services were rendered in zip code 78665, which is located in Round Rock, Texas; therefore, the Medicare participating amount is based on locality "Rest of Texas".

Therefore using the above formula, the Division finds the following:

CODE	MEDICARE PARTICIPATING AMOUNT	MAR	IC PAID	TOTAL DUE
64910	\$806.77	\$1607.04	\$1,947.71	\$2,162.93 - \$1,947.71 = \$215.22
20103	\$558.14	\$1,111.78 x 50% = \$555.89		

**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 \$215.22.

**ORDER**

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$215.22, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
Date

2/24/2017

**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, 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 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).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**