



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

DR JACK L. DEETJEN

Respondent Name

SENTRY SELECT INSURANCE CO

MFDR Tracking Number

M4-18-4989-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

AUGUST 16, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Procedure code 20670 mod LT in the amount of \$1,500.00 was billed and paid at \$294.35...The reimbursement should be \$568.04 leaving a balance of \$273.69."

Amount in Dispute: \$273.69

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have verified that this bill paid correctly according to the Texas Fee Schedule."

Response Submitted by: Sentry

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: June 27, 2018, CPT Code 20670-LT, \$273.69, \$273.69

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 medical fee disputes.
2. 28 Texas Administrative Code §134.203 effective March 1, 2008, sets the reimbursement guidelines for the disputes service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
- A90-This charge was reimbursed in accordance to the Texas medical fee guideline.
- P12-Workers compensation jurisdictional fee schedule adjustment.
- W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 350-Bill has been identified as a request for reconsideration or appeal.

Issues

- 1. What is the applicable fee guideline for professional services?

2. Is the requestor entitled to additional reimbursement for code 20670-LT?

### **Findings**

1. The applicable fee guideline for the disputed services is found at 28 Texas Administrative Code §134.203.
2. Based upon the submitted documentation the requestor billed \$1,500.00 and was paid \$294.35 for code 20670-LT. The issue in dispute is whether the requestor is due additional reimbursement of \$273.69 for code 20670-LT.

28 Texas Administrative Code §134.203(a)(5) states “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.”

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...”

CPT Code 20670 is described as “Removal of implant; superficial (eg, buried wire, pin or rod) (separate procedure.” The requestor appended modifier LT described as “Left side”

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 2018 DWC conversion factor for this service is 73.19.

Place of Service code 22 for outpatient hospital services.

The Medicare Conversion Factor is 35.9996.

Review of Box 32 on the CMS-1500 the services were rendered in Seguin, Texas.

The Medicare participating amount for code 20670 in Seguin, Texas is \$367.64.

Using the above formula, the MAR is \$747.44 or less. The respondent paid \$294.35. The difference between MAR and amount paid is \$453.09. The requestor is seeking \$273.69; this amount is recommended for reimbursement.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$273.69.

**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 \$273.69 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

09/14/2018  
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, 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**