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
WALTER GRANT BRALY

Respondent Name
TASB RISK MANAGEMENT FUND

MFDR Tracking Number
M4-06-5514-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
April 24, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This code is not global. Should be paid according to our certified coder."

Amount in Dispute: $771.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The charge in question, code 20902 for the bone graft was denied based on the American Academy of Orthopedic Surgeons, Complete Global service Data for Orthopedic Surgery. While the requestors written comments on the EOMB do indeed corroborate the description of the code which states, 'any donor area' the Global guide clearly shows that the only time that code is NOT global to the arthrodesis (27870) is when the graft is taken from a 'distant site (separate skin or fascial incision)". Based on the operative report, the events of that day clearly indicate that the bone was harvested from the same site as the incision indicating that the service is global to the primary procedure."

Response Submitted by: Texas Association of School Boards Risk Management Fund, PO Box 2010, Austin, Texas 78767

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 5, 2005	Professional Medical Services	$771.76	$771.76

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 §134.202 sets out the fee guidelines for professional medical services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - B12 – Services not documented in patients' medical records.
     - CODE DESCRIPTION AS GRAFT FROM SEPARATE SKIN/FASCIAL INCISIONS. GRAFT FROM ANKLE, ARTHRODESIS ON ANKLE, SAME INCISIONS.
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration.
     - 10/22/05 CODE DOES NOT DESCRIBE SERVICE DONE; THEREFORE CODE IS NOT DOCUMENTED IN MEDICAL RECORD AS CODE BILLED WAS NOT DONE. GRAFT WAS TAKEN FROM "SAME" SITE AS SURGICAL PROCEDURE. 20902 IS GRAFT FROM "SEPARATE" SITE. GRAFT WAS DONE, BUT NOT FROM SEPARATE SITE.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Are the insurance carrier's denial reasons supported?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. Review of the explanation of benefits finds mention that "Network reductions have been made per ROCKPORT HEALTHCARE GROUP contractual agreement." No network reduction was taken for the service in dispute, and the insurance carrier did not use a denial code indicating that a contractual agreement applies to the service in dispute. Review of the submitted information found no documentation to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on August 27, 2012, the Division requested the respondent to provide a copy of the referenced contract between TASB Risk Management Fund and the alleged network, as well as a copy of the contract between the alleged network and the health care provider, pursuant to former 28 Texas Administrative Code §133.307(l), effective January 1, 2003, 27 Texas Register 12282, which states that "The commission may request other additional information from either party to review the medical fee issues in dispute. The other additional information shall be received by the division within 14 days of receipt of this request." The respondent did not submit copies of the requested information. Accordingly, the Division concludes that the services in dispute are not subject a contracted amount. The services will therefore be reviewed according to applicable Division rules and fee guidelines.
2. This dispute relates to professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.202(b), effective January 5, 2003, 27 *Texas Register* 4048 and 12304, which requires that "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." §134.202(c) further requires that "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%."
3. Review of the submitted information finds as follows:
   - The insurance carrier denied disputed services with reason code B12 – "Services not documented in patients' medical records."; with additional notations "CODE DESCRIPTION AS GRAFT FROM SEPARATE SKIN/FASCIAL INCISIONS. GRAFT FROM ANKLE, ARTHRODESIS ON ANKLE, SAME INCISIONS." and "10/22/05 CODE DOES NOT DESCRIBE SERVICE DONE; THEREFORE CODE IS NOT DOCUMENTED IN MEDICAL RECORD AS CODE BILLED WAS NOT DONE. GRAFT WAS TAKEN FROM "SAME" SITE AS SURGICAL PROCEDURE. 20902 IS GRAFT FROM "SEPARATE" SITE. GRAFT WAS DONE, BUT NOT FROM SEPARATE SITE."
   - The requestor asserts that "This code is not global. Should be paid according to our certified coder."
   - The respondent asserts that "The charge in question, code 20902 for the bone graft was denied based on the American Academy of Orthopedic Surgeons, Complete Global service Data for Orthopedic Surgery. While the requestors written comments on the EOMB do indeed corroborate the description of the code which states, 'any donor area' the Global guide clearly shows that the only time that code is NOT global to the arthrodesis (27870) is when the graft is taken from a 'distant site (separate skin or fascial incision)". Based on the operative report, the events of that day clearly indicate that the bone was harvested from the same site as the incision indicating that the service is global to the primary procedure."
   - The disputed service is procedure code 20902, which is defined as "Bone graft, any donor area; major or large"
   - Review of Medicare's correct coding initiative edits finds that code 20902 is not bundled with code 27870.

- The respondent relies on guidance published in the American Academy of Orthopedic Surgeons Complete Global Service Data for Orthopaedic Surgery as the basis for the denial of payment. Review of the respondent's information finds no documentation to support that the policy cited as the basis for the denial of payment is related to a Medicare payment policy as required by §134.202(b).
- Further, review of the respondent's excerpted information from the American Academy of Orthopedic Surgeons Complete Global Service Data for Orthopaedic Surgery finds that procedure code 20902 is specifically listed in the section of intraoperative services that are "not included in the global service package."
- Review of the operative report finds that the donor area is the distal fibula. Documentation supports that "the cancellous bone from the distal fibula was packed across the fusion site where appropriate in terms of filling any voids or defects." The documentation supports that the fusion site includes the anteromedial and lateral ankle. The documentation supports that the graft was applied to a separate anatomical site from the donor site.
- Review of the operative report finds that the donor material was obtained from an incision "over the distal fibula/lateral malleolus."
- Documentation supports a separate incision "over the anteromedial aspect of the ankle."

The Division concludes that the respondent has failed to support that the denial reason relates to a Medicare payment policy. Moreover, the submitted documentation supports that the donor material was taken and grafted at separate anatomical sites through separate incisions. The submitted documentation supports the services as billed. The Division finds that the insurance carrier's denial reasons are not supported. Reimbursement is therefore recommended per applicable Division rules and fee guidelines.

4. Reimbursement is calculated per §134.202(c)(1) as follows: The Medicare payment amount for procedure code 20902 for 2005 for a facility located in Houston, Texas, is $617.41. This amount multiplied by 125% results in a MAR of $771.76.
5. The total recommended payment for the services in dispute is $771.76. The insurance carrier has paid $0.00, leaving an amount due to the requestor of $771.76. 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 $771.76.

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 $771.76 plus applicable accrued interest per 28 Texas Administrative Code §134.803, and/or §134.130 if applicable, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Grayson Richardson
Medical Fee Dispute Resolution Officer

May 16 2014
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

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