Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

C M SCHADE MD PHD
2692 W WALNUT STREET SUITE 105
GARLAND TX 75042

Respondent Name:
HOPKINS COUNTY MEMORIAL HOSPITAL

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number:
M4-08-1250-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These services were preauthorized as medically necessary services were billed appropriately in accordance with guidelines, Rules, and policies established by Division of Workers' Comp."

Amount in Dispute: $12,443.31

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: It is the Respondent's understanding that this dispute involves surgical services and follow-up performed on the dates of service 10/27/06 – 12/2/06 for a total amount in controversy of $12,433.31." "**The treatment was disputed because the documentation submitted to obtain the preauthorization from the utilization review company (UR herein) IMO, was misleading if not false, and therefore, in violation of Rule 134.600(f)(3). Respondent is denying these bills based upon lack of medical necessity, exceeding the scope of the preauthorization, not based upon a proper referral (claimant's treating doctor was, at the time, Dr. Charles Gordon,) and the services were not provided or authorized by a designated provider**. This matter has already been referred by Respondent to Legal and Enforcement and the Quality Review Committee." "…She was referred to Dr. Aaron Calodney in 2003 and continued

conservative care." "…Dr. Calodney then discontinued accepting workers compensation patients and discharged claimant from care." "…Dr. Schade was not the treating doctor, nor was he referred by the treating doctor. Therefore, he had no statutory authority to treat this Claimant, surgically or otherwise request preauthorization for additional treatment. Respondent asserts that the surgical procedures performed, violated the preauthorization process, were not performed at the director of a treating physician or referral physician, and were not medically necessary. Also, all follow-up care would not be considered medically necessary, as the surgical procedures were not medically necessary. Requestor is owed no additional reimbursement in this matter.

Response Submitted by: Christine B. Karcher, Downs Stanford, P.C., 2001 Bryan Street, Suite 4000, Dallas, TX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 27, 2006 November 24, 2006	CPT Codes 63655-62, 63655-51-62	$3,842.64	$1,801.22
October 27, 2006	CPT Code 63685-62	$597.58	$186.73
October 27, 2006 November 24, 2006	CPT Code 95972, 95972-62	$279.22	$206.76
October 27, 2006	CPT Code 64999-62	$3,500.00	$0.00
October 27, 2006 November 24, 2006	CPT Code 22899-62	$4,000.00	$0.00
November 30, 2006 December 1, 2006 December 2, 2006	CPT Code 99232	$213.87	$213.84

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, titled *MDR of Fee Disputes*, effective December 31, 2006, 31 TexReg 10314, sets out the procedures for health care providers to pursue a medical fee dispute.

2. 28 Texas Administrative Code §134.202, titled *Medical Fee Guideline*, effective August 1, 2003, 27 TexReg 4048 and 12304, sets out the fee guidelines for the reimbursement of professional medical services.

3. Texas Labor Code §408.021, titled *Entitlement to Medical Benefits,* requires the treating doctor to approve or recommend treatment.

4. 28 Texas Administrative Code §134.600**,** titled *Preauthorization, Concurrent Review, and Voluntary Certification of Health Care,* effective May 2, 2006 sets out the requirements for preauthorization, concurrent review and voluntary certification of specific treatment and services.

5. 28 Texas Administrative Code §133.240, titled *Medical Payment and Denials*, effective May 2, 2006, 31 TexReg 3544, prohibits the insurance carrier from denying preauthorized treatment based upon medical necessity.

6. 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006, 31 TexReg 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."

7. Texas Labor Code §413.011(d) titled *Reimbursement Policies and Guidelines; Treatment Guidelines and Protocols* requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

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

Explanation of benefits dated January 18, 2007

- 150-Payment adjusted because the payer deems the information submitted does not support this level of service.
- 165-Payment denied/reduced for absence of, or exceeded referral.
- 38-Services not provided or authorized by designated (network/primary care) providers.
- 62-Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
- W9-Unnecessary medical treatment based on peer review.
- Preauthorization obtained on insufficient data by healthcare provider. Treatment exceeded preauthorization process.
- 18-Duplicate claim/service.

Explanation of benefits dated February 6, 2007

- 150-Payment adjusted because the payer deems the information submitted does not support this level of service.
- 165-Payment denied/reduced for absence of, or exceeded referral.
- 38-Services not provided or authorized by designated (network/primary care) providers.
- 62-Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
- W9-Unnecessary medical treatment based on peer review.
- Preauthorization obtained on insufficient data by healthcare provider. Treatment exceeded preauthorization process.

Explanation of benefits dated February 13, 2007

- 150-Payment adjusted because the payer deems the information submitted does not support this level of service.
- 165-Payment denied/reduced for absence of, or exceeded referral.
- 38-Services not provided or authorized by designated (network/primary care) providers.
- 62-Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
- W9-Unnecessary medical treatment based on peer review.
- W4-No additional reimbursement allowed after review of appeal/reconsideration.
- Preauthorization obtained on insufficient data by healthcare provider. Treatment exceeded preauthorization process.

Explanation of benefits dated June 7, 2007

- 150-Payment adjusted because the payer deems the information submitted does not support this level of service.
- 165-Payment denied/reduced for absence of, or exceeded referral.

- 38-Services not provided or authorized by designated (network/primary care) providers.
- 62-Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
- W9-Unnecessary medical treatment based on peer review.
- W4-No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Did the requestor obtain a referral from the treating doctor for the disputed treatment?
2. Was preauthorization obtained for the disputed services per 28 Texas Administrative Code §134.600?
3. Was the respondent's denial of medical necessity appropriate per 28 Texas Administrative Code §133.240?
4. Did the respondent support EOB denial reason code "18"?
5. Is the requestor entitled to reimbursement for CPT code 63655-62, and 63655-51-62?
6. Is the requestor entitled to reimbursement for CPT code 63685-62?
7. Is the requestor entitled to reimbursement for CPT code 95972?
8. Is the requestor entitled to reimbursement for CPT code 99232?
9. Did the requestor support position that amount sought for CPT codes 22899-62 and 64999-62 are fair and reasonable? Is the requestor entitled to reimbursement for CPT codes 22899-62 and 64999-62?

Findings

1. The respondent denied reimbursement for the disputed services based upon EOB denial reason code "165-Payment denied/reduced for absence of, or exceeded referral" and "38-Services not provided or authorized by designated (network/primary care) providers."

   The respondent further states in the position summary that reimbursement was denied for the disputed services because treatment was "…**not based upon a proper referral (claimant's treating doctor was, at the time, Dr. Charles Gordon,) and the services were not provided or authorized by a designated provider.**" "…She was referred to Dr. Aaron Calodney in 2003 and continued conservative care." "…Dr. Calodney then discontinued accepting workers compensation patients and discharged claimant from care."

   Texas Labor Code §408.021(c), states "Except in an emergency, all health care must be approved or recommended by the employee's treating doctor."

   On the disputed dates of service, the claimant's treating doctor was Dr. Charles Gordon.

   The requestor submitted a letter from Dr. Gordon to Dr. Aaron Calodney approving the referral of the claimant for treatment to Dr. Schade; therefore, the disputed treatment was in accordance with Texas Labor Code §408.021(c). The respondent's EOB denial code of "165" is not supported.

2. The respondent denied reimbursement for the disputed services based upon "62-Payment denied/reduced for absence of, or exceeded, pre-certification/authorization," and "38-Services not provided or authorized by designated (network/primary care) providers." 28 Texas Administrative Code §134.600(p)(1)(3) effective May 2, 2006, requires preauthorization for "(1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay," and "(3) spinal surgery."

   The requestor submitted copies of the following reports to support position that the disputed services were preauthorized:

   - August 16, 2006: preauthorization approval for three inpatient days for procedures coded 63650, 76003, RC111.
   - October 2, 2006: preauthorization approval for three inpatient days for procedures coded 95972, 63685, 76005, 63655, RC111.
   - October 19, 2006: preauthorization approval for three inpatient days for procedures coded 63655, RC111, 95972, 63685, 76005.

- November 22, 2006: preauthorization approval for one inpatient day for procedures coded 99234, 63555, 95972, 22109 and RC111.
- December 1, 2006: preauthorization approval for one extra inpatient day.
- December 7, 2006: preauthorization for December 1, 2006 inpatient stay was given; December 2 and 3, 2006 were not authorized; and November 29 through November 30, 2006 was not addressed due to emergency reported status.

The Division finds that the requestor obtained preauthorization approval for the disputed services; therefore, the insurance carrier's EOB denial reason codes of "62" and "38" are not supported.

3. The respondent denied reimbursement for the disputed services based upon "W9-Unnecessary medical treatment based on peer review."

   28 Texas Administrative Code §133.240(b) states "For health care provided to injured employees not subject to a workers' compensation health care network established under Insurance Code Chapter 1305, the insurance carrier shall not deny reimbursement based on medical necessity for health care preauthorized or voluntarily certified under Chapter 134 of this title (relating to Benefits--Guidelines for Medical Services, Charges, and Payments)." The respondent preauthorized the disputed treatment; therefore, the medical necessity issue is moot.

4. The Respondent denied reimbursement based upon "18-Duplicate claim/service". The requestor submitted a duplicate bill for reconsideration of payment. The Respondent did not provide information/documentation of duplicate payments. Therefore, this payment denial reason has not been supported.

5. 28 Texas Administrative Code §134.202(b) states "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."

   28 Texas Administrative Code §134.202 (c)(1) states "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%. For Anesthesiology services, the same conversion factor shall be used."

   On October 27, 2006, the requestor billed the following CPT codes: 63655-62, 63655-51-62, 63685-62, 95972, 22899-62, and 64999-62.

   On November 24, 3006, the requestor billed the following CPT codes: 95972-62, 22899-62, 63655-62, and 63655-51-62.

   CPT code 63655-62 is defined as "Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural," with modifier "62-Two surgeons."

   Modifier -62 describes when two surgeons work together as primary surgeons performing distinct part(s) of a surgical procedure. The reimbursement methodology for modifier -62 is 125% of the established fee, divided equally between the co-surgeons. Each surgeon is reimbursed 62.5% of the fee schedule amount.

   CPT code 63655's established fee is $768.53.

   The formula to determine the maximum allowable reimbursement, MAR, when two surgeons are involved is the Medicare allowable of $768.53 multiplied by 125% = $960.66. This amount is divided by two (for the two surgeons) = $480.33 multiplied by the DWC conversion factor of 125% = $600.41. The requestor billed this procedure on October 27 and November 24, 2006; therefore, $600.41 multiplied by 2 = $1,200.82, this amount is recommended for reimbursement.

   CPT code 63655-51-62 is defined as "Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural," with modifier "51 – Multiple procedures" and "62-Two surgeons." CPT code 63655 is not exempt from the multiple procedure rule discounting; therefore, the MAR of $600.41 is

multiplied by 50% = $300.20. The requestor billed this procedure on October 27 and November 24, 2006; therefore, $300.20 multiplied by 2 = $600.40, this amount is recommended for reimbursement.

6. CPT code 63685-62 is defined as "Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling," with modifier "62-Two surgeons."

   CPT code 63685's established fee is $478.06.

   Using the above formula, the Medicare allowable of $478.06 is multiplied by 125% = $597.57. This amount is divided by two (for the two surgeons) = $298.78 multiplied by the DWC conversion factor of 125% = $373.47. CPT code 63685 is not exempt from the multiple procedure rule discounting; therefore, the MAR of $373.47 is multiplied by 50% = $186.73. This amount is recommended for reimbursement.

7. CPT code 95972 is defined as "Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour."

   The November 24, 2006 bill indicates that the requestor appended modifier "62" to CPT code 95972. Per Medicare coding policy, modifier 62 is not appropriate to be used with code 95972.

   CPT code 95972's established fee is $82.71.

   The MAR is calculated by multiplying the Medicare allowable of $82.71 by the DWC conversion factor of 125% = $103.38. The requestor billed this procedure on October 27 and November 24, 2006; therefore, $103.38 multiplied by 2 = $206.76, this amount is recommended for reimbursement.

8. On November 30, December 1, and December 2, 2006, the requestor billed CPT code 99232 defined as "Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit." The requestor's documentation supports two of the three components required for CPT code 99232; therefore, reimbursement is recommended.

   CPT code 99232's established fee is $57.03.

   The MAR is calculated by multiplying the Medicare allowable of $57.03 by the DWC conversion factor of 125% = $71.28. The requestor billed this procedure on three dates; therefore, $71.28 multiplied by 3 = $213.84, this amount is recommended for reimbursement.

9. CPT code 22899-62 is defined as "Unlisted procedure, spine," with modifier "62-Two surgeons."

   Medicare has not established a fee for this code.

   CPT code 64999-62 is defined as "Unlisted procedure, nervous system," with modifier "62-Two surgeons."

   Medicare has not established a fee for this code.

   CPT codes 22899-62 and 64999-62 are subject to the provisions of Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of

an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

Division rule at 28 TAC §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:

- The requestor's position summary states that "These services were preauthorized as medically necessary services were billed appropriately in accordance with guidelines, Rules, and policies established by Division of Workers' Comp."
- The requestor billed $2,000.00 for CPT code 22899-62 on October 27, 2006 and November 24, 2006 for a total of $4,000.00.
- The requestor billed $3,500.00 for CPT code 64999-62 on October 27, 2006.
- The requestor did not discuss or explain how payment of $7,500.00 would result in a fair and reasonable reimbursement for CPT codes 22899-62 and 64999-62.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of $7,500.00 would be a fair and reasonable rate of reimbursement for CPT codes 22899-62 and 64999-62. Additional payment cannot be 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 $2,408.55.

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 $2,408.55 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

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it 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. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).