



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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

MARK H. HENRY, MD

Respondent Name

STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number

M4-15-3505-02

Carrier's Austin Representative

Box Number 45

MFDR Date Received

June 23, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Attaching the clinical notes for DOS to help, also can be review and processed correctly, we find that the claim was not paid at the TDI-DWC allowable are required by Texas law, and contractual agreement."

Amount in Dispute: \$3,916.47

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office received an initial medical bill on 2/4/2015 for dates of service 10/29/2014, after review it was determined that the CMS 1500 was incomplete and not legible to be read. The bill was returned to the provider on 2/5/2015 (Exhibit A). A complete medical bill was received on 3/6/2015, where an audit determined that documentation was missing and a denial was issued for 16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. The cost containment vendor failed to utilize the primary denial CARC code 29-The time limit for filing has expired. A request for reconsideration was received on 4.6.2015, where an audit was performed and denied for the audit vendor's internal code or 5301 - Denying charges due to medical services not being authorized. However, further review of the services performed determined that the services were performed on an emergency basis and did not require preauthorization. Furthermore, the audit should have reflected a denial for 29-Time limit for filing has expired. Upon review of the requestor's dispute packet, the Office did not locate evidence to substantiate that the initial billing was received by the carrier within 95 days from date of service. The Office will have the audit corrected to reflect the denial of 29...."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Table with 4 columns: Date(s) of Service, Disputed Services, Amount In Dispute, Amount Due. Rows include CPT codes for Emergency Room E&M, Tendon Repair Finger, and Hand Surgery, with a TOTAL row at the bottom.

AMENDED FINDINGS AND DECISION

This **amended** findings and decision supersedes all previous decision rendered in the medical payment dispute involving the above requestor and respondent.

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 out the reimbursement guidelines for professional services.
3. The services in dispute were reduced/denied by the insurance carrier with the following reason codes:
 - 16-Claim/service lacks information, which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
 - 110-Service cannot be reviewed without operative report and bill.
 - W3-Additional payment made on appeal/reconsideration.
 - 5301-Denying charges due to medical services not being authorized.

Issues

1. Does a timely filing issue exist in this dispute?
2. Does a preauthorization issue exist in this dispute?
3. Does the documentation support billing CPT codes 99285-57, 26418-F6, 26418-F7 and 26037?
4. Is the requestor entitled to reimbursement for CPT codes 99285-57, 26418-F6, 26418-F7 and 26037?

Findings

1. The respondent states in the position summary "the audit should have reflected a denial for 29-Time limit for filing has expired. Upon review of the requestor's dispute packet, the Office did not locate evidence to substantiate that the initial billing was received by the carrier within 95 days from date of service. The Office will have the audit corrected to reflect the denial of 29."

28 Texas Administrative Code §133.307(d)(2)(F) states, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section."

A review of the submitted explanation of benefits finds that the respondent did not deny the disputed services based upon timely filing; therefore, this new denial reason or defense will not be considered in the review.

2. According to the explanation of benefits, the respondent denied reimbursement based upon reason code "5301." The respondent states in the position summary "further review of the services performed determined that the services were performed on an emergency basis and did not require preauthorization." The Division concludes that a preauthorization issue does not exist in this dispute.
3. The respondent also denied reimbursement for the disputed services based upon reason code "16."
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."

- CPT code 99285 is defined as “Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.”
- CPT code 26418 is defined as “Repair, extensor tendon, finger, primary or secondary; without free graft, each tendon.” The requestor appended modifier “F6-Right hand, 2nd digit,” and “F7-Right hand, third digit” to code 26418.
- CPT code 26037 is defined as “Decompressive fasciotomy, hand (excludes 26035).”

The Operative Report indicates that the claimant underwent the following procedures: “Right fasciotomy and debridement of multiple trauma wounds on right hand all the way down to tendon levels, code 26037; Repair of partial extensor laceration zone III, index, code 26418, right; and Repair of partial extensor laceration zone III, right long, code 26418, right.”

The Division finds that the Operative Report supports billed services; therefore, reimbursement per 28 Texas Administrative Code §134.203(c) (1) (2) is recommended.

4. 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 place of service indicated on the bill is 23 - Hospital Outpatient.

The 2014 DWC conversion factor for surgery is 69.98.

The 2014 DWC conversion factor for an Evaluation & Management service is 55.75.

The Medicare Conversion Factor is 35.8228

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77004, which is located Houston, Texas; therefore, the Medicare participating amount is based on locality “Houston, Texas”.

Codes 26418-F6 and 26418-F7 are subject to multiple procedure rules discounting (50% of MAR).

