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
PATEL VISHAL MD

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-15-3709-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
July 13, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary with the DWC060 request.

Amount in Dispute: $50,972.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office performed an in-depth review of the services provided for date of service 2/27/2015. Upon verification with our Workers' Compensation Health Care Network IMO, it was determined that Dr. Patel is not an IMO network provider. Further research of the claim and dispute packet did not reveal documentation that IMO had authorized Dr. Patel to provide services to the in-network injured workers."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 27, 2015	63075, 22554-59, 63710-59, 22845, 22851 & 20936-59	$25,766.00	$5413.58
February 27, 2015	63075-AS-59, 22554-AS-59, 63710-AS-59, 22845-AS & 22851-AS	$25,203.00	$0.00
TOTAL		$50,972.00	$5413.58

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

1. 28 Texas Administrative Code §133.307, sets out the procedures for resolving medical fee disputes.
2. Texas Insurance Code Chapter 1305 applicable to Health Care Certified Networks.
3. 28 Texas Administrative Code §133.20 sets out the procedures for Medical Bill Submission by Health Care Provider.
4. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 59 – Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
   - 78 – The allowance for this procedure was adjusted in accordance with multiple surgical procedure rules and/or guidelines.
   - 86 – Service performed was distinct or independent from other services performed on the same day.
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 197 – Payment denied/reduced for absence of precertification/authorization.
   - 199 – Number of services exceeded utilization agreement.
   - 242 – Services not provided by network/primary care providers.
   - 243 – Services not authorized by network/primary care providers.
   - 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
   - 593 – The recommended allowance based on the value of surgical assistance performed by licensed non-physician.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 4063 – Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting.
   - 309 – The charge for this procedure exceeds the fee schedule allowance.
   - W3 – Additional payment made on appeal/reconsideration.

Issues

1. Did the Requestor obtain an out-of-network referral and preauthorization authorized by the network pursuant to Section 1305.103?
2. Did the requestor submit documentation to support the billing of the assist at surgery charges?
3. Did the requestor bill in accordance with 28 Texas Administrative Code §134.203?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor seeks reimbursement for surgery services provided at Irving/Coppell Surgical Hospital, dba Baylor Surgical Hospital at Las Colinas on February 27, 2015.

   The requestor filed this medical fee dispute to the Division pursuant to 28 Texas Administrative Code (TAC) §133.307 titled *MDR of Fee Disputes*. The authority of the Division of Workers' Compensation is to apply Texas Labor Code statutes and rules, including 28 TAC §133.307, is limited to the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305. In particular, TIC §1305.153 (c) provides that "Out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation."

   Texas Insurance Code Section 1305.006 states, in pertinent part, "(3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103."

   The requestor therefore has the burden to prove that the condition(s) outlined in the Texas Insurance Code §1305.006 were met in order to be eligible for dispute resolution. The Division finds the following:

   Texas Insurance Code Section 1305.103 requires that "(e) A treating doctor shall provide health care to the employee for the employee's compensable injury and shall make referrals to other network providers, or request referrals to out-of-network providers if medically necessary services are not available within the network. Referrals to out-of-network providers must be approved by the network. The network shall approve a referral to an out-of-network provider not later than the seventh day after the date on which the referral is requested, or sooner if circumstances and the condition of the employee require expedited approval. If the network denies the referral request, the employee may appeal the decision through the network's complaint process under Subchapter I."

The requestor has the burden to prove that it obtained the appropriate approved out-of-network referral for the out-of-network healthcare it provided. The Division finds that the requestor submitted a copy of an e-mail correspondence dated February 17, 2015 from Jessica Stone with SORM which states "Dr. Patel, Correct the surgery has been approved and you as an out of network doctor have been approved to perform it at the specified facility on the letter. What I was advised is this preauthorization should cover you for the surgery and post-op visit. If you think there is a chance you need to provide medical for her on an on-going basis then I would get the form completed."

The Division finds that the requestor submitted sufficient documentation to support that the insurance carrier authorized the out of network healthcare and approved the out of network healthcare provider to render the disputed services. As a result, the requestor has met the requirements of Texas Insurance Code Section 1305.103(3). The disputed services are therefore eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

2. The requestor Patel C. Vishal, M.D., seeks reimbursement for the assist at surgery charges rendered on February 27, 2015. Review of the CMS-1500 documents Patel C. Vishal, M.D as the provider who rendered the disputed assist at surgery charges.

   Per 28 Texas Administrative Code §133.20 states, "(d) The health care provider that provided the health care shall submit its own bill, unless: (1) the health care was provided as part of a return to work rehabilitation program in accordance with the Division fee guidelines in effect for the dates of service; (2) the health care was provided by an unlicensed individual under the direct supervision of a licensed health care provider, in which case the supervising health care provider shall submit the bill 3) the health care provider contracts with an agent for purposes of medical bill processing, in which case the health care provider agent may submit the bill; or (4) the health care provider is a pharmacy that has contracted with a pharmacy processing agent for purposes of medical bill processing, in which case the pharmacy processing agent may submit the bill."

   Review of the submitted documentation does not document any of the exceptions identified 28 Texas Administrative Code §133.20 (d) (1-4). Review of the operative report, identifies, Jimmy Callahan, RNFA as the assistant surgeon. The Division finds that the requestor has not met the billing requirements outlined in 28 Texas Administrative Code §133.20. As a result, the requestor is not entitled to reimbursement for the assist at surgery charges.

3. The requestor seeks reimbursement for surgery services rendered on February 27, 2015 by Dr. Patel C. Vishal. Review of the submitted documentation finds that the disputed services were preauthorized and therefore are subject to review pursuant to 28 Texas Administrative Code §134.203.

   Per 28 Texas Administrative Code §134.203 (b) 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; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The Division completed NCCI edits to determine NCCI edit conflicts that could affect reimbursement. The requestor billed the following CPT Codes; 63075, 22554-59, 63710, 22845, 22851, and 20936-59 on February 27, 2015. The following was identified:

   Payment for procedure CPT Code 20936 is always bundled into payment for other services not specified and no separate payment is made, per Medicare. As a result, reimbursement cannot be recommended for CPT Code 20936.

   Per CCI Guidelines, procedure code 22554 has a CCI conflict with procedure code 63075. Review documentation to determine if a modifier is appropriate. Review of the CMS-1500 documents that the requestor appended modifier -59 to CPT Code 22554. Modifier -59 is defined by Medicare as follows:

"The *CPT Manual* defines modifier 59 as follows: **Distinct Procedural Service:** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used..."

Review of the submitted documentation does not meet the requirements for appending modifier -59 to CPT Code 22554. As a result, the requestor is not entitled to reimbursement for this code.

No NCCI edits were identified for the remaining CPT Codes, as a result, reimbursement is recommended for CPT Codes 63075, 63710, 22845 and 22851.

Per Medicare payment policies, CPT Codes

4. The disputed CPT Codes CPT Codes, 63075, 63710, 22845 and 22851. Medicare pays for multiple surgeries by ranking from the highest MPFS amount to the lowest MPFS amount. When the same physician performs more than one surgical service at the same session, the allowed amount is 100% for the surgical code with the highest MPFS amount. The allowed amount for the subsequent surgical codes is based on 50% of the MPFS amount. To determine which surgeries are subject to the multiple surgery rules, you review the rank assigned by Medicare for each surgery code. Review of the Medicare MPFS documents the following rank for the surgery codes billed by the requestor:

   CPT Code 22845 has a rank indicator of "0"; as a result, the multiple surgery rules do not apply.

   CPT Code 22851 has a rank indicator of "0"; as a result, the multiple surgery rules do not apply.

   CPT Code 63075 and 63710 has a rank indicator of "2", as a result, "Base payment for each ranked procedure code on the lower of the billed amount: 100% of the fee schedule amount for the highest valued procedure; and 50% of the fee schedule amount for the second through the fifth highest valued procedure." CPT Code 63075 has the highest value and is therefore paid at 100% of the MAR and CPT Code 63710 is paid at 50%.

   28 Texas Administrative Code 134.203 states in pertinent part, "(c) 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 recommended reimbursement amount for the disputed services is as follows:

   The MAR for CPT Code 22845 is $1,176.54, therefore this amount is recommended.

   The MAR for CPT Code 22851 is $655.29, therefore this amount is recommended.

   The MAR for CPT Code 63075 is $2,713.42, therefore this amount is recommended.

   The MAR for CPT Code 63710 is $868.33, therefore this amount is recommended.

   Total recommended amount $5,413.58.

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 $5,413.58.

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 $5,413.58 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		April 29, 2016
Signature	Medical Fee Dispute Resolution Officer	Date
		April 29, 2016
Signature	Medical Fee Dispute Resolution Director	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.