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**
TAMI ORR, NP

**Respondent Name**
TX ASSOC OF COUNTIES RMP

**MFDR Tracking Number**
M4-16-3002-01

**Carrier's Austin Representative**
Box Number 01

**MFDR Date Received**
MAY 31, 2016

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Enclosed please find copies of the 2 explanation of benefits, request for reconsideration HCFA form, original HCFA form, appeal letter for timely filing, proof of timely filing, and the operative report for above-cited date of service. We received the first denied EOB on 12-9-15 for timely filing. We requested reconsideration on 1-27-16 with proof of timely filing, and on 2-24-16 the carrier still denied payment for this surgery bill that was filed on time originally on 7-1-15. We would just ask the carrier to reconsider their denial and reprocess this surgery bill for payment as it was filed on time on 7-1-15 originally as you can see by the proof of timely filing from our system as well as the date on the bottom left box of claim form."

**Amount in Dispute:** $52,240.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Upon reconsideration the carrier has determined payment is owed in the amount of $1,565.56. Payment detail is attached."

**Response Submitted by:** Parker & Associates, L.L.C.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| June 26,2015 | CPT Code 22633-AS<br>Lumbar Spine Fusion | $12,800.00 | $0.00 |
| | CPT Code 63047-AS-59<br>Lumbar Laminectomy | $9,600.00 | $0.00 |
| | CPT Code 22842-AS<br>Post Segmental Instrumentation | $6,720.00 | $0.00 |
| | CPT Code 63048-AS<br>Laminectomy, Additional Level | $4,800.00 | $0.00 |
| | CPT Code 22634-AS<br>Spine Fusion, Additional Level | $3,520.00 | $0.00 |
| | CPT Code 22851-AS<br>Spinal Instrumentation | $3,200.00 | $0.00 |
| | CPT Code 22851-AS-59<br>Spinal Instrumentation | $3,200.00 | $0.00 |

| | | | |
|---|---|---|---|
| June 26, 2015 | CPT Code 38220-AS-51<br>Bone Marrow Aspiration | $2,400.00 | $34.97 |
| | CPT Code 20936-AS<br>Spinal Autograft | $1,920.00 | $0.00 |
| | CPT Code 20938-AS<br>Spinal Autograft | $1,920.00 | $0.00 |
| | CPT Code 27299-AS-51<br>Unlisted Procedure | $1,920.00 | $0.00 |
| | CPT Code 77002-AS-26<br>Professional Component<br>Needle Localization by X-Ray | $240.00 | $0.00 |
| TOTAL | | $52,240.00 | $34.97 |

## *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 a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.1, effective March 1, 2008, provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29-The time limit for filing has expired.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - W3-Additional payment made on appeal/reconsideration.
   - 54-Multiple physicians/assistants are not covered in this case.
   - 59-Processed based on multiple or concurrent procedure rules.
   - 97-The benefit for this service is included in the pymt/allowance for another service/procedure that has already been adjudicated.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - R51B-The procedure does not fall within the Medicare multiple procedure guidelines. Therefore recommended payment is based on 100% of the allowed amount for the procedure billed or the billed amount, whichever is less.
   - P14-The benefit for this service is included in the payment/allowance for another service/procedure that has been performed on the same day.

### Issues

1. Does a timely filing issue exist in this dispute?
2. Is the requestor entitled to additional reimbursement for CPT codes 22633-AS, 63047-AS-59, 63048-AS, 22842-AS, 22634-AS, 22851-AS, 22851-AS-59, 38220-AS-51 and 20938-AS?
3. Is the requestor entitled to reimbursement for CPT code 20936-AS?
4. Is the allowance of CPT code 27299-AS-51 included in the allowance of another service/procedure billed on the disputed date of service?
5. Is the allowance of CPT code 77002-AS-26 included in the allowance of another service/procedure billed on the disputed date of service?

### Findings

1. A review of the submitted explanation of benefits finds that the respondent initially denied reimbursement for the disputed services based upon "29-The time limit for filing has expired." The respondent submitted a

response to the request for dispute resolution stating "Upon reconsideration the carrier has determined payment is owed in the amount of $1,565.56. Payment detail is attached." The Division concludes that the respondent did not maintain the denial; therefore, a timely filing issue does not exist in this dispute.

2. According to the explanation of the respondent paid $1565.56 for the following services. The Division reviewed the fee schedule to determine if additional reimbursement is due for CPT codes 22633-AS, 63047-AS-59, 63048-AS, 22842-AS, 22634-AS, 22851-AS, 22851-AS-59, 38220-AS-51, and 20938.

   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."

   Medicare Claims Processing Manual, Chapter 12, Section 120.1 titled Limitations for Assistant-at-Surgery Services Furnished by Nurse Practitioners and Clinical Nurse Specialists (Rev. 2656, Issuance: 02-07-13, Effective: 02-19-13, Implementation: 02-19-13) states, "Medicare law at section 1833(a)(1)(O) of the Social Security Act authorizes payment for services that NPs and CNSs furnish as an assistant-at-surgery. Specifically, when a NP or CNS actively assists a physician in performing a surgical procedure and furnishes more than just ancillary services, the NP's and CNSs' services are eligible for payment as assistant-at-surgery services… The A/B MAC (B) shall pay covered NP and CNS assistant-at-surgery services at 80 percent of the lesser of the actual charge or 85 percent of the 16 percent that a physician is paid under the Medicare Physician Fee Schedule. Since physicians are paid at 16 percent of the surgical payment amount under the Medicare Physician Fee Schedule for assistant-at-surgery services, the actual payment amount that NPs and CNSs receive for assistant-at-surgery services is 13.6 percent of the amount paid to physicians.
   Only the AS modifier must be reported on the claim form when a NP or CNS bills assistant-at-surgery services"

   28 Texas Administrative Code §134.203(b)(1) 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; 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."

   Per 28 Texas Administrative Code §134.203(c)(1)(2) states, "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 2015 DWC conversion factor for this service is 70.54.

   The Medicare Conversion Factor is 35.9335.

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 76017, which is located in Arlington, Texas; therefore, the Medicare participating amount is based on locality "Fort Worth, Texas".

   The requestor appended modifier AS. Per Medicare Surgery Policy Manual, the Nurse Practitioner for assistant at surgery receives 85 percent of 16 percent.

Using the above formula and Medicare payment policies, the following Table lists the CPT codes and the Divisions' findings:

| CPT CODE | MEDICARE PARTICIPATING AMOUNT | MAXIMUM ALLOWABLE REIMBURSEMENT | INSURANCE CARRIER PAID | TOTAL AMOUNT DUE |
|---|---|---|---|---|
| 22633 | $1,880.40 | $3,691.36 X 85% of 16% = $502.02 | $590.62 | $0.00 |
| 63047-59 | $1,119.56 | $1,098.89 X 85% of 16% = $149.45 | $175.82 | $0.00 |
| 22842 | $776.10 | $1,523.54 X 85% of 16% = $207.20 | $243.77 | $0.00 |
| 63048 | $215.62 | $423.27 X 85% of 16% = $57.56 | $67.72 | $0.00 |
| 22634 | $504.83 | $991.01 X 85% of 16% = $134.78 | $158.56 | $0.00 |
| 22851 | $430.48 | $845.06 X 85% of 16% = $114.93 | $130.11 | $0.00 |
| 22851-59 | $430.48 | $845.06 X 85% of 16% = $114.93 | $130.11 | $0.00 |
| 38220-59 | $167.81 | $329.42 X 85% of 16% = $44.80 | $9.83 | $34.97 |
| 20938 | $195.48 | $383.74 X 85% of 16% = $52.18 | $59.02 | $0.00 |

3. Based upon the submitted explanation of benefits, the respondent paid $0.00 for CPT code 20936-AS based upon reason code "54-Multiple physicians/assistants are not covered in this case."

   Per coding guidelines, the requestor incorrectly appended modifier "AS" because this code is not reimbursable by an assistant at surgery; therefore, no reimbursement is recommended.

4. According to the explanation of the respondent denied reimbursement for CPT code 27299-AS-51 based upon reason code "97-The benefit for this service is included in the pymt/allowance for another service/procedure that has already been adjudicated."

   CPT code 27299 is an unlisted procedure or service. The requestor noted on the submitted medical bill that code 27299 was billed for the "Reconstruction of the iliac crest." The Division finds that the respondent did not support that the service was global to any other procedure rendered on the disputed date of service; therefore, the respondent's denial is not supported.

   28 Texas Administrative Code §134.203(f) states "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)." Medicare does not assign a relative value or payment fee schedule for CPT code 27299; therefore, reimbursement is in accordance with §134.1.

   28 Texas Administrative Code §134.1, requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(f) which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or 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.

28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought of $1,920.00 for CPT code 27299-AS-51 would be a fair and reasonable rate of reimbursement. As a result, payment cannot be recommended.

5. According to the explanation of the respondent denied reimbursement for CPT code 77002-AS-26 based upon reason code "97-The benefit for this service is included in the pymt/allowance for another service/procedure that has already been adjudicated."

   Per CCI edits, CPT code 77002 is a component of 22633; however, a modifier is allowed to differentiate the service. A review of the submitted medical bill finds that the requestor appended modifier 26-professional component to code 77002. Modifier -26 does not differentiate the service from 22633; therefore, the respondent's denial based upon reason code "97" is supported.

## 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 $34.97.

## *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 $34.97 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| | | |
|---|---|---|
| | | 07/18/2016 |
| Signature | Medical Fee Dispute Resolution Officer | 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**.