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
WILLIAM D. STRINDEN, MD

MFDR Tracking Number
M4-19-4198-01

MFDR Date Received
MAY 22, 2019

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

Indemnity Insurance Co's Austin Representative
Box Number 15

Response Submitted By:
Helmsman Management Services LLC

REQUESTOR'S POSITION SUMMARY

"CPT code 26449 was performed 7 times…According to the Texas Workers Comp Fee Schedule, the MAR is calculated on the medicare RVU's taking into consideration the geographic indices and the 2019 conversion factor for outpatient facility which is 74.29…I am requesting additional payment of 1344.00."

RESPONDENT'S POSITION SUMMARY

"CPT 26449 BILLED FOR 7-Seven units. 5-Five units were paid. 2-Two units were denied. Medically Unlikely Edits for Code 26449 is 5 with MUE Adjudication Indicator [MAI] of 3 Date of Service Edit: Clinical…Provider did not meet adequate documentation of medical necessity…Therefore denied as 4394."

SUMMARY OF FINDINGS

Dates of Service	Table of Disputed Services	Amount in Dispute	Amount Ordered
January 3, 2019	Seven units of 26449	$1,344.00	$1,344.00
January 3, 2019	Five units of 26410	$0.00	$0.00

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, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.
3. 28 Texas Administrative Code §134.600 sets out the rules for preauthorization.
4. The services in dispute were reduced/denied by the respondent with the following claim adjustment reason codes:
    - 97-Payment is included in the allowance for another service/procedure.

- 4394-The billing of the procedure code has exceeded the National Correct Coding Initiative Medically Unlikely Edits amount for the number of times this procedure can be billed on a date of service. An allowance has either not been paid or the maximum allowance for the MUE has been paid.
- 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.

Issues

1. Is there a dispute over code 26410?
2. Are Indemnity Insurance Co's reduction / denial reasons for 26449 supported?
3. Is the requestor entitled to additional reimbursement?

Findings

1. According to the table of disputed services on the completed DWC Form-060, the requestor is not disputing the payment received for code 26410. There is no dispute over payment of this code.

2. The requestor disputes Indemnity Insurance Co's reduction of payment for seven units of 26449. The requestor asserts that an additional $1,344 is due.

   Indemnity Insurance Co reduced these services due to a Medicare payment policy. Specifically, Indemnity Insurance Co applied a Medically Unlikely Edit or MUE to 26449. MUE edits were implemented by Medicare in 2007. MUEs set a maximum number of units for a specific service that a provider would report under most circumstances for a single patient on a single date of service. Medicare developed MUE edits to detect potentially medically unnecessary services.

   Although the division adopts Medicare payment policies by reference in applicable Rule §134.203, paragraph (a)(7) of that rule states that specific provisions contained in the Division of Workers' Compensation rules shall take precedence over any conflicting provision adopted the Medicare program.

   The Medicare MUE payment policy is in direct conflict with Texas Labor Code §413.014 which requires that all determinations of medical necessity shall be made prospectively or retrospective through utilization review; and with Rule §134.600 which sets out the procedures for preauthorization and retrospective review of professional services such as those in dispute here. The division concludes that Texas Labor Code §413.014 and Rule §134.600 take precedence over Medicare MUE edits. For that reason, Indemnity Insurance Co's denial reasons are not supported.

   Furthermore, although there is no evidence of retrospective review by Indemnity Insurance Co, there is evidence in box 23 the medical bills provided Indemnity Insurance Co preauthorized the services in dispute. According to Rule §134.600 (c), Indemnity Insurance Co in this case is liable for payment

   The division concludes that Indemnity Insurance Co's denial reasons are not supported, and that the Indemnity Insurance Co is liable for payment as allowed under the applicable division fee guideline.

3. 28 Texas Administrative Code §134.203 applies to professional services of a surgeon. A review of the submitted billing and medical records finds that the requestor billed seven units of 26449.

   Rule §134.203 (h) states that the reimbursement is the lesser of the maximum allowable reimbursement (MAR) and the billed amount. The DWC MAR which is described at §134.203 (c)(1) & (2) is the Medicare payment multiplied by a DWC factor. The billed amount is located on the medical bills.

   To calculate DWC factor, take the applicable 2019 DWC conversion factor and divide it by the 2019 Medicare conversion factor. The DWC conversion factor applicable here is $74.29 because the services in dispute were professional services of a surgeon that performed a surgical procedure in a facility setting.

   $\$74.29 / \$36.0391 = 2.061372$

   The DWC MAR in this case is the Medicare payment for the service x 2.061372.

The table below illustrates the calculation of the total allowable reimbursement for the service in dispute

Code	Medicare Payment	Maximum Allowable Reimbursement (MAR) §134.203 (c)(1) & (2)	Billed Amount (From medical bill)	Allowable Amount §134.203 (h) (Lesser of MAR and billed amount)
26449	100% of $686.05[1]	$686.05 x 2.061372 = $1,414.20.	$1,400.00	$1,400.00
26449	50% of $686.05[2]	($343.025 x 2.061372) x 6 = $4,242.61	$8,400.00	$4,242.61
			ALLOWABLE	$5,642.61

[1]The Medicare payment for a service is different from region to region. Texas is divided into 8 localities determined by zip code. In this case the services were provided in Zip code 75904 for Lufkin Texas. The Medicare locality is “Rest of Texas”.

[2]A multiple procedure reduction as required by Medicare policy Claims Processing Manual 100-04, Chapter 12, Section 40.6. The multiple procedure reduction policy states that the first unit of each surgical code is paid at 100% while additional units are paid at a 50%.

The total allowable reimbursement for 7 units of 26449 is $5,642.61. Indemnity Insurance Co paid a total of $4,242.60 for these services. The disputed amount of $1,344.00 is due.

Conclusion

For the reasons stated above, the division finds that the requestor has established that the disputed amount is due. As a result, the amount ordered is $1,344.00.

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 $1,344.00 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 Director	July 18, 2019 Date

RIGHT TO APPEAL

Either party to this medical fee dispute may seek review of this division decision. To appeal, submit form division Form-045M titled ***Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)*** found at https://www.tdi.texas.gov/forms/form20numeric.html.

Follow the instructions on pages 3 and 4. The request must be received by the division within twenty days of your receipt of this decision. This decision becomes final if the request for review of this decision is not timely made.

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.

If you have questions about the division Form-045M, please call CompConnection at 1-800-252-7031, Option 3 or you may email your question to CompConnection@tdi.texas.gov