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
COLLOM AND CARNEY ORTHOPEDICS

Respondent Name
ACE AMERICAN INSURANCE CO

MFDR Tracking Number
M4-20-0716-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
NOVEMBER 18, 2019

REQUESTOR'S POSITION SUMMARY

"First denial-EOB states the services are not documented in op note. I contacted our compliance dept within our facility to review the op note. Ste states billing is correct and notates on the report where the CPT codes are documented. Second denial-EOB states the first review is correct and the services are not documented in op note."

Amount in Dispute: $5,548.00

RESPONDENT'S POSITION SUMMARY

"Clinical Validation will uphold all denials of the disputed charges."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 30, 2019	CPT Code 12034-LT-59	$550.00	$0.00
	CPT Code 11012-LT-59	$1,425.00	$867.05
	CPT Code 13121-RT-59	$775.00	$0.00
	CPT Code 20696-LT	$1,840.00	$0.00
	CPT Code 99222-57-25	$240.00	$0.00
	CPT Code 13122-RT-59	$350.00	$0.00
	CPT Code 20696-LT-AS	$368.00	$0.00
TOTAL		$5,548.00	$867.05

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 (DWC).

Background

1. 28 Texas Administrative Code §133.307, effective May 31, 2012 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16-Claim/service lacks information or has submission billing error(s).
   - 112-Service not furnished directly to the patient and/or not documented.
   - 59-Processed based on multiple or concurrent procedure rules.
   - B12-Services not documented in patient's medical records.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - W3-Request for reconsideration.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to reimbursement for the surgical and hospital services rendered on June 30, 2019?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $5,548.00 for CPT codes 12034-LT-59, 11012-LT-59, 13121-RT-59, 20696-LT, 99222-57-25, 13122-RT-59 and 20696-LT-AS rendered on June 30, 2019.
2. The respondent denied reimbursement for the disputed services based upon "B12-Services not documented in patient's medical records," "112-Service not furnished directly to the patient and/or not documented," and "16-Claim/service lacks information or has submission billing error(s)."
3. The fee guidelines for disputed services is found at 28 TAC §134.203.
4. 28 TAC §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."
5. 28 TAC §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."
6. The disputed services are described as:
   - 12034-Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 7.6 cm to 12.5 cm.
   - 11012-Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, muscle, and bone.
   - 13121-Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm.
   - 20696-Application of multiplane (pins or wires in more than 1 plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; initial and subsequent alignment(s), assessment(s), and computation(s) of adjustment schedule(s).
   - 99222-Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate 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 problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.

- 13122-Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure).

- 20696-Application of multiplane (pins or wires in more than 1 plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; initial and subsequent alignment(s), assessment(s), and computation(s) of adjustment schedule(s).

A review of the requestor's billing finds that the requestor appended modifier "59-Distinct Procedural Service" to CPT codes 12034, 11012, 13121, 13122, and 20696.

Modifier 59 is described as "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."

7. The DWC finds:

Code 12034:

- The respondent wrote, "Agree with previous CV denial. Documented procedure does not appear to match the code description of the CPT code billed. Wound length is not documented for 12034, Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 7.6cm to 12.5cm."
- Per CCI guidelines; procedure code 12034 is bundled with code 20696; however, a modifier is allowed to differentiate the service. Based upon the billing 12034 and 20696 were performed on the left side. [REDACTED]."
- The requestor's documentation does not indicate [REDACTED] for code 12034.
- The requestor did not support billing or reimbursement for code 12034.

Code 13121:

- The respondent wrote, "Uphold previous CV denial. Documented procedure does not appear to match the code description of the CPT code billed. Wound length is not documented for 13121 Repair, complex, scalp, arms, and/or legs 2.6cm to 7.5cm.
- Per CCI guidelines; procedure code 13121 is bundled with code 20696; however, a modifier is allowed to differentiate the service. Based upon the billing 13121 was performed on the right side and 20696 was on the left side. [REDACTED]"
- The requestor's documentation does not indicate the [REDACTED] for code 13121.
- The requestor did not support billing or reimbursement for code 13121.

Code 20696 and 20696-LT-AS:

- The requestor billed for the surgeon and assistant surgeon services.
- The respondent wrote, "Uphold previous CV denial. Documented procedure does not appear to match the code description of the CPT code billed. Stereotactic computer-assisted adjustment is not documented for 20696 Application of multiplane (pins or wires in more than 1 plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; initial and subsequent alignment(s), assessment(s), and computation(s) of adjustment schedule(s).
- The Operative report indicates, [REDACTED]."

- The requestor's documentation does not indicate "external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; initial and subsequent alignment(s), assessment(s), and computation(s) of adjustment schedule(s)."
- The requestor did not support billing or reimbursement for code 20696 and 20696-LT-AS.

Code 99222:

- The respondent wrote, "Uphold previous CV denial. Documentation on the CMS 1500 or UB04 is not supported by the information in the medical record. 99222, Initial hospital care, per day, of the evaluation and management of a patient is not documented.
- Per CCI edits, code 99222 is bundled with 11012, 20696, and 13121; however, a modifier is allowed to differentiate the service. The requestor appended modifiers "57" and "25" to code 99222.
- Modifier 57 is described as "Evaluation and Management (E/M) service resulted in the initial decision to perform surgery either the day before a major surgery (90 day global) or the day of a major surgery." Modifier 25 is described as "significant, separately identifiable evaluation and management (E/M) service by the same physician on the same day of the procedure or other service."
- The requestor did not submit a separate report to support billing code 99222.
- The requestor did not support billing or reimbursement for code 99222.

Code 13122:

- Per CCI guidelines; procedure code 13122 is bundled with code 20696; however, a modifier is allowed to differentiate the service. Based upon the billing 13122 was performed on the right side and 20696 was on the left side.
- The Operative report indicates, "[REDACTED]."
- The requestor's documentation does not indicate the [REDACTED] for code 13122.
- The requestor did not support billing or reimbursement for code 13122.

Code 11012:

- The respondent wrote, "Uphold previous CV denial. Documented procedure does not appear to match the code description of the CPT code billed. Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, muscle, and bone is not documented."
- The Operative report indicates, "[REDACTED]."
- The requestor documentation supports billing and reimbursement for code 111012.

Per 28 TAC §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 services were rendered in zip code 75501, which is located in Texarkana, Texas; therefore, the Medicare participating amount is based on locality “Rest of Texas”.

The 2019 DWC conversion factor for this service is 74.29.

The 2019 Medicare Conversion Factor is 36.0391

The Medicare participating amount for code 11012 at this location is $420.62.

Using the above formula, the DWC finds the MAR is $867.05. The respondent paid $0.00. The requestor is due the difference between MAR and amount paid of $867.05.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $867.05.

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 DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of $867.05 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	1/15/2020 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, effective May 31, 2012, *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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR 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 DWC. **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.