TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
QUINTESSENCE PLASTIC SURGERY

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-22-1893-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
May 2, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 27, 2021	11043, 11046, 25260 and 64857	$45,505.82	$10,885.48
	Total	$45,505.82	$10,885.48

Requestor's Position

"Due to the pandemic and subsequent loss of staff in the office, the provider was running the office herself for an extended period of time. This is why the claim was not submitted immediately. There is no reason that the physician should not get paid for this surgery. We are hoping to resolve this matter quickly. I have attached a copy of the billing history that shows that it was sent out electronically on 08/16/2021 which is within the 95-day timely filing period. It was also mailed out with medical records. Please assist us in getting this claim paid."

Amount in Dispute: $45,505.82

Respondent's Position

"The provider disputes the denial citing the pandemic, however per Commissioners order B-0004-21, Governor Abbott resumed tolled (paused) medical billing deadlines effective 3/01/2021. The date of service on this bill is 5/27/2021 therefore the bill should have been received within 95 days from the date of service."

Response Submitted by: Texas Mutual Insurance Company

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the fee guideline for professional medical services.
3. 28 TAC §133.20 sets out the medical bill submission procedures for health care providers.
4. 28 TAC §133.230 sets out the guidelines for insurance carrier audit of a medical bill.
5. 28 TAC §133.240 sets out the guidelines for medical payments and denials.
6. 28 TAC §102.4 sets out the rules for non-Commission communications.
7. TLC §408.027 sets out the rules for timely submission of claims by health care providers.
8. TLC §408.0272 provides for certain exceptions to untimely submission of a medical bill.
9. Texas Insurance Code Chapter 1305 applies to health care certified networks.

Denial Reasons

Neither the requestor nor the respondent submitted EOBs with the DWC060 request/response.

Issues

1. Did the requestor submit the bills for audit, prior to filing for Medical Fee Dispute Resolution?
2. Did the insurance carrier raise a new issue after the filing of the DWC060 request?
3. Did the requestor obtain an out of network approval to treat the in-network injured employee?
4. Are there NCCI edit conflicts that could affect reimbursement?
5. Are the services in dispute subject to the multiple surgery reduction?
6. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for surgery services rendered on May 27, 2021.

   The requestor seeks reimbursement for CPT Codes 11043, 11046, 25260 and 64857 rendered on May 27, 2021. No EOBs were submitted with the DWC060 request. It is the duty of the workers' compensation insurance carrier **or an agent acting on the insurance carrier's behalf** to pay, reduce, or deny a complete medical bill within 45 days from receiving the bill. The 45-day deadline to make or deny payment is not extended as a result of an audit under 28 TAC §133.230 or as a result of a pending request for additional documentation.

   Further, the insurance carrier **must** notify the health care provider of its final action by issuing an explanation of benefits (EOB) and must include on its EOB any bill reductions, denial reasons, and defenses in the form and manner required under 28 TAC §133.240.

   Review of the medical documentation supports that the requestor submitted a medical bill to the insurance carrier prior to the filing of the MFDR. As a result, the disputed services are eligible for review.

2. The insurance carrier raises the 95-day timely filing issue in their response to the MFDR request, however presented no EOBs to support the denial.

   Under 28 TAC §133.307, DWC only reviews those denial reasons and defenses presented by the insurance carrier to the health care provider before the date the request for MFDR was filed. Any denial reasons or defenses the insurance carrier raises after the filing of the dispute are not considered in the review of the medical fee dispute.

3. The requestor seeks reimbursement for in the amount of $45,505.82, for surgery codes 11043, 11046, 25260 and 64857 rendered on May 27, 2021. The requestor submitted a copy of a WorkWell network referral.

   The requestor filed this medical fee dispute to the Division asking for resolution pursuant to 28 TAC §133.307 titled *MDR of Fee Disputes*. The authority of the Division of Workers' Compensation to resolve matters involving employees enrolled in a certified health care network is limited to the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305 and limited application of Texas Labor Code statutes and rules, including 28 TAC §133.307.

   Texas Insurance Code §1305.106 provides that "An insurance carrier that establishes or contracts with a network is liable for the following **out-of-network** health care that is provided to an injured employee... (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."

   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."

   The Division finds that the requestor obtained an out-of-network referral and therefore, the disputed services are under the jurisdiction of the Division of Workers' Compensation and are eligible for medical fee dispute resolution under 28 TAC §133.307.

4. 28 TAC §134.203 (b) states in pertinent part, "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 DWC completed NCCI edits to identify potential edit conflicts that may affect reimbursement. The following was identified:

   - 11043 – This charge line did not trigger edits and is considered clean.
   - 11046 – This charge line did not trigger edits and is considered clean.
   - 25260 x 18 units – Per Medicare's Medically Unlikely Edits, the units of service billed for procedure code 25260 exceed the allowed number of units of 9 in 1 Day for date of service. The requestor did not append a modifier to override the limit of 9 units.
   - 64857 x 2 units – This charge line did not trigger edits and is considered clean.

The DWC finds no edit conflicts that would affect reimbursement for CPT Codes 11043, 11046, 64857, the requestor is therefore entitled to reimbursement for CPT Codes 11043, 11046 and 64857. The DWC finds that a limit of 9 units is allowed per Medicare's Medically Unlikely Edits. As a result, reimbursement is recommended for 9 units.

5. Review of the Medicare Claims Processing Manual, Chapter 12, 40.6, Claims for Multiple Surgeries defines multiple surgeries as "…separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed. Co-surgeons, surgical teams, or assistants-at-surgery may participate in performing multiple surgeries on the same patient on the same day."

   It further states that reimbursement is determined "Base payment for each ranked procedure (indicator '2') on the lower of the billed amount, or:

   - 100 percent of the fee schedule amount for the highest valued procedure;
   - 50 percent of the fee schedule amount for the second through the fifth highest valued procedure."

   Using the formula indicated in 28 TAC 134.203 (c) and the Medicare Claims Processing Manual, Chapter 12, 40.6, Claims for Multiple Surgeries reimbursement is calculated below:

   (* - This CPT Code is not in dispute, however, is included to identify edit conflicts that may affect reimbursement.)

   - 64857 – Highest RVU
     This code contains a status indicator 2
     This code is not subject to the multiple procedure rule 100% reimbursement.
   - 11046
     This code contains a status indicator 0
     This code is not subject to the multiple procedure rule 100% reimbursement.
   - 25260
     This code contains a status indicator 2
     This code is subject to the multiple procedure rule discounting of 50%
   - 11043
     This code contains a status indicator 2
     This code is subject to the multiple procedure rule discounting of 50%.

6. 28 TAC §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 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…"

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

- The date of service is May 27, 2021.
- The 2021 DWC Surgery Conversion Factor is 76.76.
- The 2021 Medicare Conversion Factor is 34.8931.
- Per the medical bills, the services were rendered in zip code 78665, TX; therefore, the Medicare locality is "Rest of Texas."

The Medicare Participating amount for CPT code 11043 at this locality is $149.42.

- Using the above formula, the DWC finds the MAR is $328.70 minus the 50% reduction the recommended amount is $164.35.
- The respondent paid $0.00.
- Reimbursement of $164.35 is recommended.

The Medicare Participating amount for CPT code 11046 at this locality is $53.35.

- Using the above formula, the DWC finds the MAR is $117.36.
- The respondent paid $0.00.
- Reimbursement of $117.36 is recommended.

The Medicare Participating amount for CPT code 25260 at this locality is $617.20.

- Using the above formula, the DWC finds the MAR is $1,357.75 x 9 units = $12,219.79 minus the 50% reduction the recommended amount is $6,109.89.
- The respondent paid $0.00.
- Reimbursement of $6,109.89 is recommended.

The Medicare Participating amount for CPT code 64857 at this locality is $1,021.40.

- Using the above formula, the DWC finds the MAR is $2,246.94 x 2 units = $4,493.88.
- The respondent paid $0.00.
- Reimbursement of $4,493.88 is recommended.

The total recommended amount is $10,885.48. The requestor is entitled to an additional reimbursement amount of $10,885.48.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The DWC finds the requester has established that additional reimbursement of $10,885.48 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor $10,885.48 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 13, 2022
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.