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
MARK HOWARD HENRY MD

Respondent Name
SENTRY INSURANCE COMPANY

MFDR Tracking Number
M4-22-2015-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
May 16, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 12, 2021	26037	$1,576.82	$651.74
	Total	$1,576.82	$651.74

Requestor's Position

"The healthcare provider's position on this claim is that the services have been underpaid. We find that none of the services billed on the claim were paid at 100% of the statutory fee as required by law per Texas Administrative Code Title 28 Part 2 Chapter 134 Subchapter C Rule 134.202."

Amount in Dispute: $1,576.82

Respondent's Position

"After a careful review of the submitted documentation originally submitted with the bill and the documentation on reconsideration, Optum has determined that the documentation did not support the billed charges defined under Texas Administrative Code Title 28. Part 2, Chapter 133, subchapter B, Rule 133.20, C and AMA CPT definition or intent for code 26037. Optum does not dispute the need for treatment and did not dispute payment based on medical necessity of services but rather on the lack of documentation to support reporting such services.
In review of the operative reports submitted, Optum found the services were not supported based on 134.203 Medical Fee Guidelines for Professional Services."

Response Submitted by: Sentry

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.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- P12 – Workers' Compensation jurisdictional fee schedule adjustment.
- 150 – Payer deems the information submitted does not support this level of service.
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
- 2 (350) – Bill has been identified as a request for reconsideration or appeal.
- 3(329) – Allowance for this service represents 50% because of multiple or bilateral rules.
- 5 (CCL) – Clinical coding logic.
- 6 (CRU) – Re-evaluation, no additional allowance.

Issues

1. Is the Insurance Carrier's denial reason supported?
2. Does the multiple procedure payment reduction rule apply?
3. What is the maximum allowable reimbursement (MAR) for the disputed CPT code?
4. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 26037-LT rendered on August 12, 2021.

   The insurance carrier denied/reduced the disputed service with reductions codes indicated above.

   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."

   Review of the CMS-1500's documents that the requestor billed the following CPT Codes on disputed date of service, August 12, 2021:

   CPT Code 26037 is defined as "The physician decompresses the hand fascia. The physician incises the skin overlying the affected fascia. The fascia is incised, and the underlying tissues are irrigated. The incision is sutured in layers."

CPT Code 26412 is defined as "Repair, extensor tendon, hand, primary or secondary; with free graft (includes obtaining graft), each tendon."

The DWC finds that the requestor rendered and documented the services as billed. As a result, the insurance carrier's denial reason is not supported.

The DWC completed NCCI edits to identify potential edit conflicts that could affect reimbursement. The following was identified:

- 26412-LT - Per Compliance Editor, this charge line did not trigger edits and is considered clean
- 26037-LT - Per Compliance Editor, this charge line did not trigger edits and is considered clean

No edit conflicts were identified that would affect reimbursement. The disputed services are therefore, reviewed pursuant to 28 TAC §134.203.

2. 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.)

   - *26412-LT – Highest RVU – This code is not subject to the multiple procedure rule 100% reimbursement.
   - 26037-LT – This code contains a status indicator 2
     This code is subject to the multiple procedure rule discounting of 50%

3. 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 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…"

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

- The disputed date of service was rendered in 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 77002; therefore, the Medicare locality is "Houston Texas."
- The Medicare Participating amount for CPT code(s) 26037 at this locality is $592.53.
- Using the above formula, the DWC finds the MAR is $1,303.48 minus the 50% reduction, the recommended amount is $651.74.
- The respondent paid $0.00.
- Reimbursement of $651.74 is recommended.

4. The DWC finds that the requestor is entitled to reimbursement in the amount of $651.74.

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 reimbursement of $651.74 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 $651.74 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 16, 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.