TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
JASON R. BAILEY, MD PA

Respondent Name
SOMPO AMERICA INSURANCE COMPANY

MFDR Tracking Number
M4-22-2414-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
July 14, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 22, 2022	11012 and 76000	$4,437.00	$450.82
	Total	$4,437.00	$450.82

Requestor's Position

"Per AAPC MCR CCI edits, codes 11012 and 76000 are allowable/payable codes with NO CCI Edits. We submitted an appeal with CCI edit documentation and the claim was re-evaluated and no additional allowance made, per EOB dated 7/01/22. I am attaching a copy of the documentation that was submitted for this claim, along with the EOB for re-evaluation."

Amount in Dispute: $4,437.00

Respondent's Position

"It is the carrier's position that the provider was reimbursed in accordance with the Medical Fee Guidelines. The charges were adjusted based on multiple surgery rules or concurrent anesthesia rules such that some of the services were included in another code billed on the same day. The Medical Fee Guidelines did not allow multiple codes billed on the same day."

Response Submitted by: Flahive, Ogden & Latson

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:

- 90563 - ORIGINAL PAYMENT DECISION IS BING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROESSED PROPERLY.
- 193 -Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 59 - CHARGES ARE ADJUSTED BASED ON MULTIPLE SURGERY RULES OR CONCURRENT ANESTHESIA RULES.
- P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.

Issues

1. Does the disputed service contain NCCI edit conflicts that could affect reimbursement?
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 additional reimbursement for CPT Codes 11012 and 76000 rendered on February 22, 2022. The insurance carrier denied/reduced the disputed services with denial reduction 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."

   The requestor appended modifier F6-Right hand, second digit.

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

   Review of the medical bill documents that the requestor billed the following CPT Codes; 11012-F6, 26756-F6, 11760-F6 and 76000.

CPT Code: 11012-F6-This charge line did not trigger edits and is considered clean.

CPT Code: 26756-F6-This charge line did not trigger edits and is considered clean.

CPT Code: 11760-F6-This charge line did not trigger edits and is considered clean.

CPT Code: 76000-Per Medicare guidelines, procedure code 76000 describes a diagnostic procedure that requires a professional component modifier in POS 22

CPT Code: Procedure code 76000 has been billed with a related procedure code 26756 without an appropriate modifier. Review of the documentation did not identify an appropriate modifier.

The DWC finds that no NCCI edit conflicts were identified for CPT Codes 11012, 26756, and 11760. As a result, the requestor is entitled to reimbursement for CPT Code 11012. Edit conflicts were identified for CPT Code 76000, as a result, the requestor is not entitled to reimbursement for this CPT Code.

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:

   - 26756 – Highest RVU – 100% of the fee schedule – Not subject to the multiple surgery reduction.
   - 11012 – Status indicator 2 – Subject to the 50% multiple surgery reduction.
   - 11760 – Status indicator 2 – Subject to the 50% multiple surgery reduction.

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 services were rendered in 2022.
- The 2022 DWC Surgery Conversion Factor is 78.37.
- The 2022 Medicare Conversion Factor is 34.6062
- Per the medical bills, the services were rendered in zip code 77304; therefore, the Medicare locality is "Rest of Texas."

* - Identifies a CPT Code that is not in dispute but was considered to determine the appropriate reimbursement.

Date of Service	CPT Code	Surgery Indicator	MPPR	MAR	Billed Amount	Insurance Carrier Pd	Amount Due
2/22/22	*26756	2	100%	$943.62	$2,843.50	$943.62	$0.00
2/22/22	11012	2	50%	$901.64 – 50% = $450.82	$4,052.40	$0.00	$450.82
2/22/22	*11760	2	50%	$244.67 – 50% = $122.34	$1,400.30	$122.34	$0.00
ECHO Service Fee Reduction				_____	_____	$-21.21	$0.00
TOTALS				$1,516.78	$8,296.20	$1,044.75	$450.82

4. The DWC finds that the requestor is therefore entitled to additional reimbursement in the amount of $450.82.

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 $450.82 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor $450.82 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		August 17, 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.