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

General Information

Requestor Name
JUAN D. ZEHR, MD

Respondent Name
ZNAT INSURANCE COMPANY

MFDR Tracking Number
M4-22-2673-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
August 19, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 22, 2022	20690 x 6	$7,770.00	$1,620.60
	Total	$7,770.00	$1,620.60

Requestor's Position

The requestor did not submit a position summary for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Amount in Dispute: $7,770.00

Respondent's Position

"The disputed code 20690 (total billed charge $7,700.00) was not supported by the submitted documentation. The provider's operative report states that only internal fixation was placed. The internal fixation is included in the CPT descriptor for billed code 26765 (Open treatment of distal phalangeal fracture, finger, or thumb, includes internal fixation, when performed, each.), which Zenith has already paid at the correct number of units. The external fixation 20690) was not documented on the report. Therefore, the original denial for disputed code 20690 should stand."

Response Submitted by: The Zenith

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:

- 224 -Duplicate charge.
- 225 -The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 16 -Claim/service lacks information or has submission/billing error(s).
- 18 -Exact duplicate claim/service

Issues

1. Do the disputed services contain NCCI edit conflicts that may affect reimbursement?
2. Does the Multiple Procedure Payment Reduction (MPPR) apply to CPT Code 20690?
3. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Codes 20690 x 6 rendered on March 2, 2022. The insurance carrier issued a payment in the amount of $1,998.19 for CPT Codes 26765 x 2 and 11760 x 2 and $0.00 for disputed CPT Code 20960 x 6.

   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 the following modifiers:

   F6-Right hand, second digit

   F7-Right hand third digit

The Division completed NCCI edits to determine if the disputed charges contain edit conflicts that may affect reimbursement. The followings was found:

The requestor billed the following CPT Codes: 20690 X 6 units and 26765 x 2 units and 11760 x 2 units.

- CPT Code 20690-F6: Per Medicare's Medically Unlikely Edits, the units of service billed for procedure code 20690 exceed the allowed number of units of 2 in 1 Day for date of service.
- CPT Code 20690-F6-59: Per Medicare's Medically Unlikely Edits, the units of service billed for procedure code 20690 exceed the allowed number of units of 2 in 1 Day for date of service.
- CPT Code 20690-F6-59-51: Per Medicare's Medically Unlikely Edits, the units of service billed for procedure code 20690 exceed the allowed number of units of 2 in 1 Day for date of service.
- CPT Code 20690-F7-59: Per Medicare's Medically Unlikely Edits, the units of service billed for procedure code 20690 exceed the allowed number of units of 2 in 1 Day for date of service.
- CPT Code 20690-F7-59-51: Per Medicare's Medically Unlikely Edits, the units of service billed for procedure code 20690 exceed the allowed number of units of 2 in 1 Day for date of service.
- CPT Code 20690-F7-59-51: Per Medicare's Medically Unlikely Edits, the units of service billed for procedure code 20690 exceed the allowed number of units of 2 in 1 Day for date of service.

The requestor appended modifier -59 to 5 of the disputed CPT codes.

CMS, MLN1783722, dated March 2022 defines modifier -59 as -"Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M (Evaluation/Management) 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."

Review of the National Correct Coding Initiative Policy Manual for Medicare Services, with Revision Date: 1/1/2022, defines Medically Unlikely Edits (MUE) - Medically Unlikely Edits (MUEs) prevent payment for a potentially inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service (UOS) reportable under most circumstances by the same provider/supplier for the same

beneficiary on the same date of service. The ideal MUE value for a HCPCS/CPT code is one that allows the vast majority of appropriately coded claims to pass the MUE.

The DWC finds that the requestor is therefore entitled to reimbursement for 1 unit of CPT Code 20690-F6 and 1 unit of CPT Code 20690-F7-59. CPT Code 20690-F7-59, the modifier -59 is supported as the requestor billed for a different site.

Review of the Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, section 40.6 - Claims for Multiple Surgeries, CMS 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. Per CMS, multiple surgeries are reimbursed as follows:

- 100 percent of the fee schedule amount (Field 34 or 35) for the highest valued procedure; and
- 50 percent of the fee schedule amount for the second through the fifth highest valued procedures

Medicare pays for multiple surgeries by ranking from the highest MPFS amount to the lowest MPFS amount. When the same physician performs more than one surgical service at the same session, the allowed amount is 100% for the surgical code with the highest MPFS amount. The allowed amount for the subsequent surgical codes is based on 50% of the MPFS amount. To determine which surgeries are subject to the multiple surgery rules, you review the rank assigned by Medicare for each surgery code. Review of the Medicare MPFS documents the following rank for the surgery codes billed by the requestor:

CPT Code 20690-F7-59 has a rank indicator of "2" as a result, "Base payment for each ranked procedure code on the lower of the billed amount: 100% of the fee schedule amount for the highest valued procedure; and 50% of the fee schedule amount for the second through the fifth highest valued procedure."

The following CPT Codes did not trigger any edit conflicts; however, they are not in dispute.

- CPT Code 26765-F6-59-51: Per Compliance Editor, this charge line did not trigger edits and is considered clean. This charge line is subject to payer review.
- CPT Code 26765-F7-59-51: Per Compliance Editor, this charge line did not trigger edits and is considered clean. This charge line is subject to payer review.
- CPT Code 11760-F6-59-51: Per Compliance Editor, this charge line did not trigger edits and is considered clean. This charge line is subject to payer review.
- CPT Code 11760-F7-59-51: Per Compliance Editor, this charge line did not trigger edits and is considered clean. This charge line is subject to payer review.

The DWC finds that the insurance carrier's denial reasons are supported, and therefore the requestor is not entitled to reimbursement for the services in dispute.

2. 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 2022 DWC Conversion Factor is 62.46
   - The 2022 Medicare Conversion Factor is 34.6062
   - Per the medical bills, the services were rendered in zip code 75251; therefore, the Medicare locality is "Dallas."

   The Medicare Participating amount for CPT code 20690-F6 at this locality is $598.60.
   - Using the above formula, the DWC finds the MAR is $1,080.40.
   - The respondent paid $0.00.
   - The requestor is entitled to $1,080.40

   The Medicare Participating amount for CPT code 20690-F7-59 at this locality is 50% of the MPFS, $299.30.
   - Using the above formula, the DWC finds the MAR is $540.20.
   - The respondent paid $0.00.
   - The requestor is entitled to $1,080.40
3. The DWC finds that the requestor is entitled to a total reimbursement amount for CPT Code 20690-F6 and 20690-F7-59 in the amount of $1,620.60.

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 $1,620.60 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 $1,620.60 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 27, 2022 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.