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

General Information

Requestor Name
LAKE POINTE ORTHOPAEDICS & SPORTS

Respondent Name
INSURANCE COMPANY OF THE STATE OF PA

MFDR Tracking Number
M4-23-0011-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 1, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 16, 2021	J3301 x 8 units and 20610-50	$504.00	$174.69
	Total	$504.00	$174.69

Requestor's Position

"We have been given two different claim adjuster names and have left many messages requesting a call back to discuss the denial. No success. The claim adjusters does not return calls and the representatives with AIG states that they can't assist us. Therefore, we are filing a TDI complaint. I have attached a copy of all the calls and communications that we have done on this bill trying to get it paid."

Amount in Dispute: $504.00

Respondent's Position

"The Table of Disputed services combines J3301 (injectable triamcinolone acetonide) and procedure code 20610 (arthrocentesis, aspiration and/or injection, major joint or bursa (e.g., shoulder, hip, knee, subacromial bursa); without ultrasound guidance. Code 20610 is classified as a minor surgery (0-day postoperative period). See M4-17-2908- 01. As a surgical procedure, it required preauthorization. And as at least the third in a series of annual injections over the years, the injection protocol used exceeds or is not covered by Division treatment guidelines, also requiring preauthorization. In addition, the drug used in the procedure (triamcinolone acetonide) is not in the closed formulary, also requiring preauthorization."

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 Texas Administrative Code (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 §134.600 sets out the guidelines for preauthorization, concurrent utilization review, and voluntary certification of health care.
4. 28 TAC §137.100 sets out the treatment guidelines.

Denial Reasons

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

- 1 – Preauthorization not obtained.

Issues

1. Is preauthorization required for CPT® 20610 and HCPCs ® J3301?
2. Do the disputed services contain NCCI edit conflicts that may affect reimbursement?
3. What is the Maximum Allowable Reimbursement (MAR) for HCPCs ® J3301?
4. What is the MAR reimbursement for CPT® 20610?
5. Is the Requestor entitled to reimbursement?

Findings

1. On the disputed date of service, the requestor billed CPT ® J3301 and 20610. The insurance carrier denied the disputed services due to lack of preauthorization.

   The requestor states, "AIG denied 20610 and J3301 for no auth obtained, did not see an auth in they system or patient's chart, set to clinic for review."

   The insurance carrier states, "Code 20610 is classified as a minor surgery (0-day postoperative period). See M4-17-2908-01. As a surgical procedure, it required preauthorization. And as at least the third in a series of annual injections over the years, the injection protocol used exceeds or is not covered by Division treatment guidelines, also requiring preauthorization. In addition, the drug used in the procedure (triamcinolone acetonide) is not in the closed formulary, also requiring preauthorization."

   28 TAC §134.600 (p)(12) states, "(p) Non-emergency health care requiring preauthorization includes… (12) treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits)."

28 TAC §137.100 (f) states, "(f) A health care provider that proposes treatments and services which exceed, or are not included, in the treatment guidelines may be required to obtain preauthorization in accordance with §134.600 of this title, or may be required to submit a treatment plan in accordance with §137.300 of this title."

28 TAC §137.100 (e) states, "(e) An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017."

The requestor seeks reimbursement for CPT® 20610 and HCPCs® J3301. Review of the knee and leg chapter of the Official Disability Guidelines (ODG) recommends injections for osteoarthritis of the knee. As a result, preauthorization is not required and the insurance carrier's denial reason is not supported.

2. 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 following CPT® codes are defined as:

   - CPT® 99213-25- Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, **20**-**29** minutes of total time is spent on the date of the encounter.
   - CPT ® 20610 – 50-Arthrocentesis, aspiration and/or injection, major joint or bursa (e.g., shoulder, hip, knee, subacromial bursa); without ultrasound guidance.
   - CPT ® J1040 - Injection, medroxyprogesterone acetate, 1 mg
   - CPT ® 73562 – LT- Radiologic examination, knee; 3 views
   - CPT ® J3301- Injection, triamcinolone acetonide, not otherwise specified, 10 mg

   The modifiers identified below are defined as:

   - Modifier® 25 - Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service
   - Modifier® 50 - Bilateral Procedure
   - Modifier® LT - Left side (Used to identify procedures performed on the left side of the body)
   - Modifier-® RT - Right side (Used to identify procedures performed on the right side of the body)

The Division completed NCCI edits to help identify edit conflicts that may affect reimbursement.

On the disputed date of service, the requestor billed the following CPT ® 99213-25, 20610-50, J3301, 73562-RT and 73562-LT.

- CPT® J3301-Has a status E- Per Medicare guidelines the procedure code billed is an item or service that is excluded from the National Physician Fee Schedule by regulation.
- CPT ® 20610- Per Compliance Editor, this charge line did not trigger edits and is considered clean.
- CPT ® 99213- Per Compliance Editor, this charge line did not trigger edits and is considered clean.
- CPT ® 73562-50- Per Medicaid Guidelines, procedure code 73562 with modifier LT with history procedure code 73562 with modifier RT does not qualify for the usual bilateral payment adjustment. Base payment for each side on the lower of the actual charge for each side or 100% of the fee schedule amount for each side.

3. 28 TAC §134.203 (d)(2) states, "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows…(2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS…"

   The Texas Medicaid Fee Schedule for HCPCs J3301 is $1.11 per unit x 8 units = $8.88 x 125% = MAR amount of $11.11, as a result this amount is recommended.

4. 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..."

   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® 20610 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 requestor billed with modifier -50 indicating that this was a bilateral procedure. As a result, the MPPR applies to CPT® 20610.

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

- The 2021 DWC Conversion Factor is 61.17
- The 2021 Medicare Conversion Factor is 34.8931
- Per the medical bills, the services were rendered in zip code 75032; therefore, the Medicare locality is "Rest of Texas."

The Medicare Participating amount for CPT® 20610 at this locality is $62.21.

- Multiple Procedure Payment Reduction (MPPR) applies
- Using the above formula, the DWC finds the MAR is $109.06 for the right side and $54.52 for the left side.
- The respondent paid $0.00.
- Reimbursement of $163.58 is recommended.

5. The DWC finds that the requestor is entitled to reimbursement to a total amount of $174.69. Therefore, this amount is recommended.

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 $174.69 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$174.69 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		November 8, 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.