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
SENTRY SELECT INSURANCE COMPANY

MFDR Tracking Number
M4-23-0459-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
October 18, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 30, 2022	20670 and 99080	$6,658.83	$692.93
	Total	$6,658.83	$692.93

Requestor's Position

"Our claim was processed reimbursed a partial payment of $61.07. Per EOB received, codes 20670 and 99080 denied. We submitted a reconsideration with documentation on 9/22/22 and received a denied EOB stating original payment decision is being maintained. I am attaching a copy of the documentation that was submitted for this claim. Please review the documents attached. I am also submitting a copy of the AAPC CCI Edits to show that both denied codes are allowable/payable codes with NO CCI edits."

Amount in Dispute: $6,658.83

Respondent's Position

"Per the documentation submitted, the K-wires numbering three were used for stabilization of the right thumb. All three wires were at the same anatomic location. This clearly supports the incorrect reporting of the number of units. We will now give supporting evidence on why the code itself was not reportable under the documented circumstances… American Academy of Orthopaedic Surgeons AAOS Now Article June 1, 2009 Step 4: Report postoperative services accurately. The application of the first postoperative splint and/or strapping is included during the global period and should not be reported separately. Removal of hardware (such as exposed K-wire) that is intended to be removed is not reimbursable separately. Removal of certain fixation may be payable if medically necessary and done surgically, as in the case of implant

removal due to infection (CPT code 20680-removal of implant; deep). If removal is performed within the surgical global period, append modifier 78 (Unplanned return to the operating/ procedure room by the same physician following initial procedure for a related procedure during the postoperative period) to the CPT code… In closing, the removal of a subcutaneous Kirshner wire (K-wire) used for stabilization is not considered an implant and is included in the surgical global package. Additionally, the code 20670 can only be reported once per anatomic site per AMC CPT. Optum does not dispute the need for treatment and did not dispute payment based on medical necessity of services but rather on the correct coding and reporting. Optum would ask the Division of Workers' Compensation to uphold the original determination of denial of reimbursement for CPT codes of 20670-58-F5."

Response Submitted by: Optum

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.

Denial Reasons

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

- W3 – In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 150Payer deems the information submitted does not support this level of service.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 59 – Processed based on multiple or concurrent procedure rules.
- P12 – Workers Compensation jurisdictional fee schedule adjustment.
- Note: No additional information received, audit upheld. Per AAOS, Global Service Data for Orthopaedic Surgery and CMS, removal of hardware (such as an exposed K-wire) that is intended to be removed is not reimbursable separately and should not be reported. CPT code 20670 is for buried wire, pin, or rod. Per the documentation report, the K-wire was not buried and did not require an incisional removal or tissue manipulation. AAOS Now June 1, 2009.
- CCL – This bill was reviewed by a specialty audit/coding expert by applying code auditing rules and edits rules and edits based on coding conventions define by AMA and coding guidelines developed by national societies and prevailing industry standards and coding practices.

Issues

1. Do the disputed service contain NCCI edit conflicts that could affect reimbursement?
2. Is the Requestor entitled to reimbursement for CPT Code 20670?

Findings

1. The requestor seeks reimbursement for CPT Codes 20670 and 99080 rendered on June 30, 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."

   - CPT Code 20670 is described as, "Removal of implant; superficial (e.g., buried wire, pin or rod) (separate procedure)."
   - CPT Code 73140 is described as, "Radiologic examination, finger(s), minimum of 2 views."
   - CPT Code 99080 is described as, "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form."
   - The requestor appended modifier F5- "Right hand, thumb."
   - The requestor appended modifier 58 – "Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period."

   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; 73140-58-F5, 20670-58-F5 and 99080.

   - CPT Code: 73140-58-F5-This charge line did not trigger edits and is considered clean.
   - CPT Code: 20670-58-F5 -This charge line did not trigger edits and is considered clean.
   - CPT Code: 99080- Per CMS guidelines, payment for procedure code 99080 is always bundled into payment for other services not specified and no separate payment is made.

   The DWC identified edit conflicts for CPT Code 99080, as a result, reimbursement cannot be recommended for this CPT Code.

   The DWC finds that no NCCI edit conflicts were identified for CPT Codes 20670, the disputed service is reviewed pursuant to the applicable rules and guidelines.

2. CPT Code 20670 is subject to review pursuant to 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 insurance carrier indicates that the disputed CPT code 20670 was rendered during a post operative period and therefore is bundled with the primary procedure performed prior to the disputed CPT Code 20670. The DWC was unable to determine whether the disputed CPT Code 20670 was or was not rendered during a post-operative period of another procedure previously performed. In addition, the previously performed procedure was not identified, and therefore the post-operative period of time cannot be identified. As a result, the insurance carrier's denial reason of "97" is not supported.

   The insurance carrier denied the disputed service due to lack of documentation. Review of the medical documentation supports the billing of CPT Code 20670. The requestor billed 3 units; however, one unit is allowed. The DWC finds that the requestor is therefore entitled to one unit of CPT Code 20670.

   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
   - The services were rendered in zip code 77090; therefore, the Medicare locality is "Houston."
   - The Medicare Participating amount for CPT code 20670 at this locality is $383.92.
   - Using the above formula, the DWC finds the MAR is $692.93.
   - The respondent paid $0.00.
   - Reimbursement of $692.93 is recommended.

3. The DWC finds that the requestor is therefore not entitled to reimbursement for CPT Code 99080 and is entitled to reimbursement for one unit of CPT Code 20670. As a result, $692.93 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 $692.93 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 $692.93 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	January 23, 2023 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.