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

General Information

Requestor Name
LANKFORD HAND SURGERY ASSN

Respondent Name
ZNAT INSURANCE COMPANY

MFDR Tracking Number
M4-23-0673-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
November 16, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 19, 2022	20670-58-59-RT	$799.00	$342.16
	Total	$799.00	$342.16

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: $799.00

Respondent's Position

"On June 17, 2022, Zenith Insurance Company ("Zenith") processed a payment of $768.54 on check number 917532 for CPT codes 99080-73, 73130, and 20670-58-RT. The service in dispute 20670-58-59-RT was denied as not substantiated by the submitted documentation... The disputed code 20670-58-59-RT ($799.20) was not supported by the submitted documentation. In addition, the provider's report does not support the use of modifier 59 (distinct service) for the service in dispute. The patient was seen on 05/19/2022 for a follow up visit post-surgical intervention with treatment of distal phalanx facture of the right middle finger. The provider's report states that the middle finger pins (Qty 2) were removed on this date. The provider's report only supports the right middle finger. Therefore, Zenith only reimbursed CPT code 20670-58-RT and the second unit billed as 20670-58-59-RT was denied as not supported by the submitted documentation. No additional payment is due."

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:

- 225 -The submitted documentation does not support the service being billed, we will re-evaluate this upon receipt of clarifying information.
- 790 -This charge was reimbursed in accordance with the Texas Medical Fee Guidelines.
- Pl3 -Payment reduced or denied based on Workers' Compensation Jurisdictional Regulations or payment policies, use only if no other code is applicable.
- Pl2 -Workers' Compensation Jurisdictional fee schedule adjustment.
- 16 -Claim/service lacks information or has submission/billing error(s).

Issues

1. Is the insurance carrier's denial reason(s) supported?
2. Does the multiple procedure payment reduction (MPPR) rule apply?
3. What is the maximum allowable reimbursement (MAR)?
4. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 20670 rendered on May 19, 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 billed CPT Code 20670-58-59-RT

CPT Code 20670 is described as, "Removal of implant; superficial (e.g., buried wire, pin or rod) (separate procedure)."

Modifier RT - Right side (Used to identify procedures performed on the right side of the body)

Modifier -58 is described as, "Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period."

Modifier -59 is described as, "Distinct Procedural Service."

The DWC finds that medical documentation supports that the procedure was performed on the right index finger and the right middle finger. As a result, the insurance carrier's denial reason is not supported and the requestor is entitled to reimbursement for the disputed service.

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:

CPT Code	Surgery Indicator	Multiple Procedure Payment Reduction (MPPR)	Medicare Physician Fee Schedule (MPFS)
*73130	0	100%	$38.35
*20670-58-RT	2	100%	$146.23
20670-58-59-RT	2	50%	$73.11

- 20670-58-RT– Highest valued procedure – 100% of the fee schedule – Not subject to the multiple surgery reduction.
- 20670-58-59-RT– Status indicator 2 – Subject to the 50% multiple surgery reduction.
- 73130-Status indicator "0" indicates that this CPT code is not subject to the MPPR.

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 62.46.
   - The 2022 Medicare Conversion Factor is 34.6062.
   - Per the medical bills, the services were rendered in zip code 75246; therefore, the Medicare locality is "Dallas."

   *Identifies a CPT Code that is not in however, was included in the review to determine the correct reimbursement.

Date of Service	CPT Code	Surgery Indicator	MPPR	MAR	Billed Amount	Insurance Carrier Pd
5-19-22	*99080-73	0	N/A	$15.00	$30.00	$15.00
5-19-22	*73130	0	N/A	$69.22	$114.70	$69.22
5-19-22	*20670	2	100%	$684.32	$799.20	$684.32
5-19-22	20670	2	50%	$684.32 – 50% = $342.16	$799.20	$0.00
			TOTALS	$1,110.70	$1,743.10	$768.54

4. The DWC finds that the total MAR for the services rendered on May 19, 2022 is $1,110.70. The insurance carrier issued a payment in the amount of $768.54 as a result, the requestor is entitled to an additional payment in the amount of $342.16.

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 $342.16 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 $342.16 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		February 27, 2023
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.