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

General Information

Requestor Name
JASON R. BAILEY, M.D., P.A.

Respondent Name
PROPERTY & CASUALTY INSURANCE CO.

MFDR Tracking Number
M4-23-0878-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
December 14, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 13, 2022	20103	$3,033.80	$450.82
	Total	$3,033.80	$450.82

Requestor's Position

"Our claim was processed and denied reimbursement for CPT code 20103 per EOB received claim was denied due to this service is an integral part of total service performed and does not warrant separate procedure charge... Based on the information provided, I am requesting that this claim be reviewed and reprocessed accordingly; it should allow correct payment for the denied code for EMERGENT surgery."

Amount in Dispute: $3,033.80

Respondent's Position

"Please accept this letter as a response to the above dispute, The bill in question was processed and partially denied by code review as: Deny 20103 msg 299 Exploration is Inclusive to other surgical services performed same enco1.mter same site, Ok to pay remaining per system
Bill was processed on 10/24/22 under control number 218640160."

Response Submitted by: The Hartford

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:

- B15 – This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.
- 299 – This service is an integral part of the total service performed and does not warrant separate procedure charge.

Issues

1. Is the Insurance Carrier's denial reason supported?
2. Does Medicare's multiple procedure payment reduction (MPPR) apply to the disputed service?
3. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 20103 rendered on September 13, 2022. The insurance carrier denied the disputed service with denial reduction code(s), "B15" and "299" description provided 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 the following CPT codes on September 23, 2022:

   - CPT Code: 11012 – "Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (e.g., excisional debridement); skin, subcutaneous tissue, muscle fascia, muscle, and bone."
   - CPT Code: 26727 – "Percutaneous skeletal fixation of unstable phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with manipulation, each."
   - CPT Code: 26776 – "Percutaneous skeletal fixation of interphalangeal joint dislocation, single, with manipulation."

- CPT Code: 26765 – "Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each."
- CPT Code: 13132 – "Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm."
- CPT Code: 20103 – "Exploration of penetrating wound (separate procedure); extremity."
- CPT Code: 11760 – "Repair of nail bed."
- CPT Code: 12002 – "Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm."
- CPT Code: 26720 – "Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each."
- CPT Code: 64450 – "Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch."
- CPT Code: 99223 – "Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, **75** minutes must be met or exceeded."
- CPT Code: 11730 – "Avulsion of nail plate, partial or complete, simple; single."
- CPT Code: 76000 – "Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time."
- CPT Code: 29125 – "Application of short arm splint (forearm to hand); staic."

Appended modifier(s):

- ET – "Emergency Services."
- 59 – "Distinct procedural service."
- F1 – "Left hand, second digit."
- FA – "Left hand, thumb."
- XE – "Separate encounter, a service that is distinct because it occurred during a separate encounter."
- XS – "Separate structure, a service that is distinct because it was performed on a separate organ/structure."
- F2 – "Left hand, third digit."
- 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."
- 57 – "Decision for surgery."

To ascertain if the disputed services contain edit conflicts that could have an impact on payment, the DWC completed NCCI edits. The DWC determines that the disputed service, CPT code 20103, which was billed on the same day as the CPT codes mentioned above, does not contain edit conflicts and is not integral to other services billed on the same day. The division therefore comes to the conclusion that the insurance carrier's justification for denial is unfounded. As a result, the requestor is entitled to reimbursement for CPT Code 20103.

2. 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: 11012 is the highest valued procedure, reimbursement at 100%.
    - CPT Code: 20103 reimbursement is at 50% for the second through the fifth highest valued procedure.

    Per Medicare payment policy, "Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage."

    The DWC finds that, "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 is therefore entitled to reimbursement at 50% of the Medicare fee schedule.

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..."

Procedure code 20103 represents a professional service with reimbursement determined per §134.203(c). Procedure code 20103 has a status indictor of two, which makes it subject to the multiple procedure payment reduction policy, as a result reimbursement is recommended at 50% of the Medicare fee schedule.

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

- The 2022 Surgery DWC 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; the Medicare locality is "Rest of Texas."
- The Medicare Participating amount for CPT code 20103 at this locality is $398.14.
- Using the above formula, the DWC finds the MAR is $901.64 at 50% = MAR $450.82.
- The respondent paid $0.00.
- Reimbursement of $450.82 is recommended.

4. The DWC finds that the requestor is entitled to 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 reimbursement of $450.82 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 $450.82 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		May 8, 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 managing the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option three 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.