Virginia Workers' Compensation Commission
EDUCATIONAL CONFERENCE
& EXHIBITION

Medical Fee Disputes Through the Lens of the Regulator

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Mission at the Commission

In response to § 65.2-605, The Medical Fee Services Department will establish and maintain medical fee schedule quality standards for the Virginia Workers' Compensation Commission. The department will provide direction, training, and information to the public on the medical fee schedule and related requirements. By facilitating an understanding of the medical fee schedule, the department's aim is to ensure the medical fee schedules are properly executed, monitored, and maintained. The Medical Fee Services Department will respond to health care providers, employers, insurance companies, and third-party administrators' medical fee schedule inquiries.

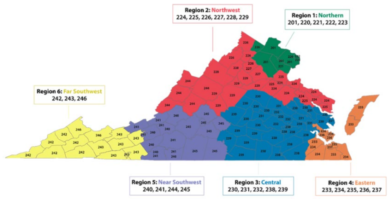
Learning Objectives

- Define the parameters for fee-scheduled medical services when ordered by the Commission.
- Review underlying considerations for the application of the schedules and rules via the Administrative Dispute Determination process.
- Experience dispute-level considerations from the Regulator's perspective and define some strategies to navigate the administrative review process.
- Identify how impacts and influences for the Virginia experience may inform Biennial year review activities.

Commission-ordered Medical Treatment

Defining the Parameters

- **Claim Jurisdiction** – Virginia
  - Status – Medical Award
- **Provider** – What type of provider is performing the services?
  - Professional – surgeon, physician non-surgeon, AS, PA, NP
  - Facility – Hospital, ASC, stand-alone surgical suite
- **Location** – Where were medical services provided?
  - Community Designation
    - 6 regions as defined by the first three positions of the zip (i.e. 224-229 = R



- **Service** – What type of service?
  - Professional services – Office visit, Surgical, Physical Medicine and Rehab
  - Facility services – Type One Teaching, Other than Type One Teaching
    - Acute, Rehabilitation

Defining the Parameters conti.

The Law Identifies Which Services are Covered by the MFS

Covered Services

- Hospital inpatient and outpatient facility services
- Services provided by an ambulatory surgical center
- Physician services
- Medical Implants
- Services provided by other medical professionals (therapies, chiropractic, dental, acupuncture)
- Ambulance services
- Pharmaceuticals administered as part of a fee scheduled medical service
- Durable medical equipment provided as part of a fee scheduled medical service

Services Explicitly Excluded

- Pharmaceuticals dispensed by providers, other than hospitals as part of inpatient or outpatient services, or part of a medical service at an ASC
- Durable medical equipment dispensed at retail

Underlying Considerations

Disputed Medical Services

What is the central issue(s) identified in the dispute?

A. The MFS dispute is the request to the Commission for assistance. It includes medical records, billing statements, and other supporting documentation. The request signals that the parties do not agree with the payment assigned for the medical services provided to the injured worker.

B. More importantly for the MFS Dept, the Dispute identifies the specific item (s) that the requestor wants the Commission to review and decide regarding the payment.

12VAC5-410-1260. Medical records.

A. Medical records. An accurate and complete clinical record or chart shall be maintained on each patient. The record or chart

Ground Rule Adjustments

Commission ordered

1. Provider Category
   a. Professional
      Surgeon
      Physician – non-surgeon
   b. Facility
      Type One Teaching
      Other Type One Teaching
2. Region – Place of service
3. Codes- Applicable rules and instructions
4. General bill level payment adjustments

Standard Language

- CPT consists of standardized language via coding methodology to bring accuracy and consistency in the communication of medical, surgical, diagnostic, and therapeutic services provided by healthcare providers.

- Within this descriptive language and associated code numbers is the nomenclature used to develop guidelines for reporting medical procedures and services for processing claims.

- While CPT does not define payment rules and guidelines, the descriptions within the codes provide additional information for reporting frequency and applicable coding combinations.

Response

MFS Dispute Response

What is the response to the identified issue(s) in the dispute?

A. Includes support that the disputed codes describe medically or non-medically necessary treatment.

B. Identifies the specific reason for either no payment or a partial payment for the code(s) describing the disputed medical treatment.

1. Missing documentation
2. National Correct Coding Initiatives Same-day service edits.
   a. Physician to Physician (PTP) Edits
   b. Medically Unlikely (MUE's) Edits
   c. Add on code(s) edits

MFS Dispute Case Reviews

The MFS Dispute cases that follow are provided as examples to inform general knowledge of the application of the Medical Fee Schedules and Ground Rules.

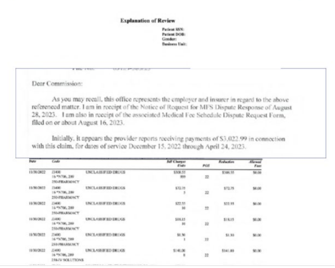
MFS Dispute Case -1

- Professional surgical services billed with codes 29824 with modifier 59, 29826 with modifier 59, 29827, and 29823 with modifier 59 to describe the medical services provided. All codes were paid with the exception of CPT code 29823.59.

MFS Dispute Request

Rotator cuff repair with debriding of the superior and medial tuberosity.

MFS Dispute Response



The reason for denial was medical services were not properly documented.

<u>Arthroscopy</u>, <u>shoulder</u>, <u>surgical</u>; debridement, extensive, 3 or more <u>discrete</u> structures

Modifier is allowed

Somewhat silent, other than applicable coding conventions must be used to describe medical services provided.

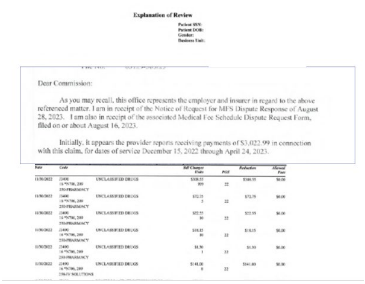
MFS Dispute Case -2

- Professional services billed with CPT 64633 and 96372 with modifier 59 to describe medical services provided. All codes were paid except for 96372 with modifier 59.

MFS Dispute Request

Medical record indicates that Xylocain and Depo-Medrol injections were provided at the same site and Midazolam(I/M) injections provided for mild sedation to relieve patient stress.

MFS Dispute Response



Denial reason indicates NCCI edit (services unbundled) and only referenced the Midazolam injection being provided.

(64633) Destruction by neurolytic agent, paravertebral facet joint nerve (s) with image guidance (fluoroscopy or CT): cervical or thoracic, single facet joint (inclusive procedure – local anesthetic and/or steroid)

(96372) Therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular

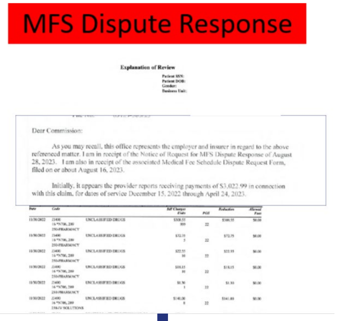
Modifier is allowed

Somewhat silent, other than applicable coding conventions must be used to describe medical services provided.

MFS Dispute Case -3

- Ambulatory Surgery Center bills facility services with Revenue codes 270 with unlisted medical-surgical supplies, 278 with HCPCS C1713, and 490 with CPT 29807. All services were initially denied. Subseqent payment was issued for CPT code 29807 only.

The operative report indicates from anterior to the biceps tendon, to posterior to biceps tendon with grade II with anchor.



Denial reason indicates a copy of the invoice for the implant was required prior to payment consideration.

Arthroscopy, shoulder, surgical; repair of SLAP lesion

shoulder pathology may be described as "from anterior to the biceps tendon, to posterior to the biceps tendon," which denotes the SLAP orientation.

Expressly defined language in the Ground Rules that Implant invoices are not required to issue payment.

Medical Documentation

MFS Dispute 1

CPT code description included key terms:

- resource use complexity- “extensive”
- defined quantity- “3”
- proximity- “more discrete” means individually separate and distinct

MFS Dispute 2

CPT guidelines for the primary procedure identified key variables:

- general anesthesia + steroid injections inclusive to the procedure
- separate and distinct injection for other purposes identified in the medical record

MFS Dispute 3

CPT code description included key terms:

- full description of procedure vs. acronym

Expressly written Ground Rule language:

- Implant invoices are not required

Biennial Reviews and the Experience

Influences and Impacts

- **Biennial Review Process Refinements-** Developed a process for the removal and or addition of new codes not previously listed on the schedules. Added additional codes with per-unit maximum fees.
- **Ground Rule Updates**

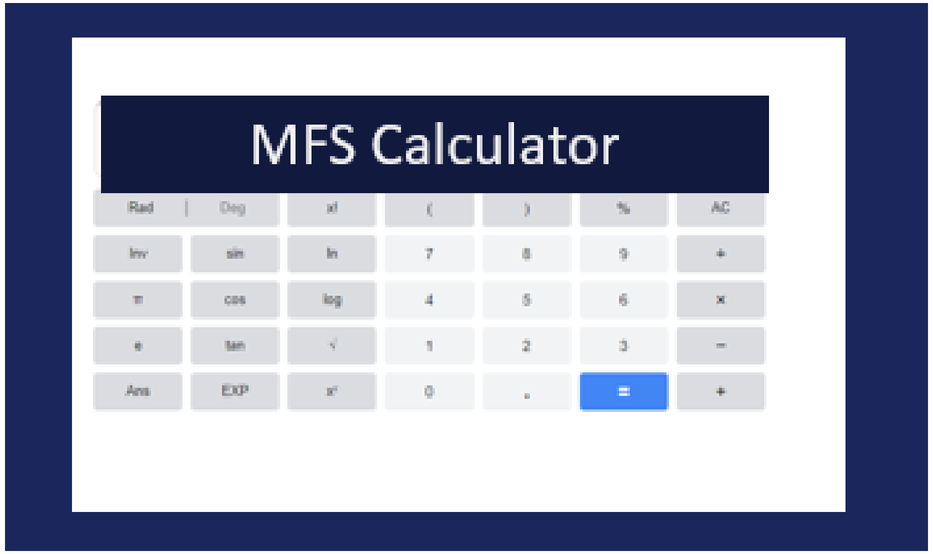
  Definitions- were added for Deleted Codes, Dispense, New Types of Procedure, Retail or Mail order Prescription Drugs, and Taxonomy Code, Advances in Technology, Fixed Amount Per Service, and Fixed Amount Per Unit

  Payment Rules for modifiers 80, 81, 82, AS, and AD were clarified. Clarifications in the Billing and Payment section.

  Adjustments to the maximum fee to reflect revised code definitions.

New Commission Tools

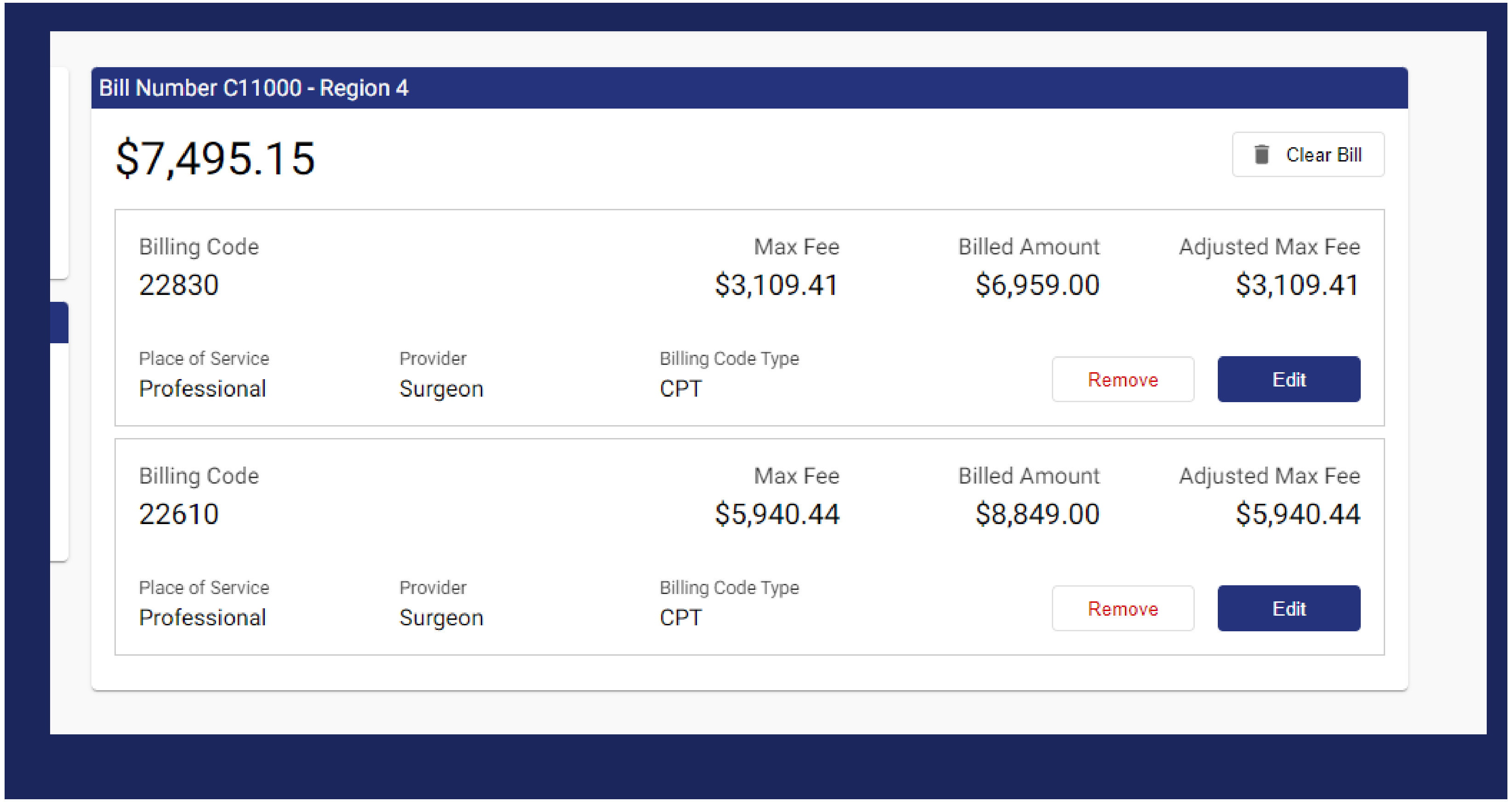
Max Fee Calculations



The MFS Calculator is a convenient tool that determines regional classifications and maximum rates of payments. The Calculator incorporates applicable Ground Rules adjustments at the bill level to return the combined fee scheduled maximum assigned amount.

Ground Rule Adjustment

Many of the Ground Rules will be incorporated to provide the adjusted maximum fee.



Exportable Outcomes

New Report Functionality

Users will be provided an option to export the results obtained from the calculator into Excel or PDF file format.

JCN00001732789 - Region 3 Professional

Billing Code	DOS	Provider	Units	Max Fee	Billed Amount	Ground Rule Adjustment	Adjust
10035	01/01/2022	Non-Surgeon	1	$ 1,970.22	$ 500.00	$ 500.00	$ 500.00
10021	01/01/2022	Non-Surgeon	1	$ 322.01	$ 25.00	$ 12.50	$ 12.50
11045	01/01/2022	Non-Surgeon	1	$ 103.70	$ 58.24		$ 58.24
		FEE SCHEDULE MAXIMUM AMOUNT					$ 570.74

9/26/23, 3:26 PM MFS Calculator

Bill Number: 321
Region 3

DOS	POS	Code	Mod	Billed	Adjusted Max Fee
Aug 8, 2023	Professional	10035		$500.00	$500.00
Aug 8, 2023	Professional	10021		$25.00	$12.50
Aug 8, 2023	Professional	11045		$58.24	$58.24

Questions??

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