Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
AUSTIN PAIN ASSOCIATES

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-11-2861-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
APRIL 20, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Not included in primary procedure."

Amount in Dispute: $608.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The epidurography was performed in the C7-T1 epidural space. (See operative report, requestor's DWC-60.) The cervical epidural steroid injection was performed at the C7-T1 epidural space. Both were performed on the same claimant the same date, the same operative session and same anatomic site. This is sufficient information to show the requestor's use of the -59 modifier cannot be employed in the way he does because two procedures, the epidurography and the ESI are in an anatomically identical region. The use of the -59 modifier in this instance violates Medicare's interpretation provided with the Attachment…Texas Mutual bundled 72275 to the fluoroscopy used to perform the ESI. That the rquestor did not bill the fluoroscopy code per se makes no difference. For this reason no payment is due for code 72275."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 28, 2011	CPT Code 72275-26-59	$608.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, *33 Texas Register 364*, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

- 217-The value of this procedure is included in the value of another procedure performed on this date.
- CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 724-No additional payment after a reconsideration of services.

Issues

Is the value of CPT code 72275 included in the value of code 62310 rendered on the disputed date? Is the requestor entitled to additional reimbursement?

Findings

Per 28 Texas Administrative Code §134.203(b)(1) "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: 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."

According to the submitted explanation of benefits, the respondent denied reimbursement for code 72275-26-59 based upon reason codes "CAC-97 and 217."

On the disputed date of service, the requestor billed CPT codes 62310, 72275-26-59, and 99144.

According to the CCI edits, CPT code 72275 is global to 62310; however, a modifier is allowed to differentiate the service. The requestor appended modifier "59-Distinct Procedural Service" to code 72275.

Modifier "59" is defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

A review of the submitted operative report indicates that both CPT code 62310 and 72275 were performed at C7-T1 intervertebral space. The Division finds that the submitted reports do not support a "different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual." The Division concludes that the requestor has not supported the use of modifier "59." As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	6/4/2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.