



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

ABILENE DIAGNOSTIC CLINIC
PETER C. GROTHAUS, MD

Respondent Name

TRAVELERS INDEMNITY CO OF CONN

MFDR Tracking Number

M4-14-3720-01

Carrier's Austin Representative

Box Number 05

MFDR Date Received

AUGUST 25, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the 2014 NCCI edits (copy attached) when Column One procedure is 15004 and Column Two procedure is 13151, there is a bundling issue but the use of a modifier is allowed. The previously submitted appeal appended modifier -59 to procedure 13151. Your denial of this service is incorrect."

Amount in Dispute: \$598.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider seeks separate reimbursement for CPT code 15004 on the basis that it was identified as a separate procedure by the use of the -59 modifier. First, the Provider appended the -59 modifier to CPT code 13151, not CPT code 15004. Therefore, the billing does not reflect that CPT code 15004 was a separate procedure. Second, in reviewing the documentation there does not appear to be support for the proposition that there were two separate procedures as required by the use of -59 modifier...The services herein were rendered to the same injured area (the upper lip) in the same surgical session and to the same surgical site. There is no documentation of any of the differentiating factors supporting the application of the -59 modifier."

Response Submitted by: Travelers/Atty. William E. Weldon

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 9, 2013	CPT Code 15004 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children	\$598.50	\$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, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W1-Per the NCCI Outpatient Code Editor, your services have been disallowed.
 - 76-Charge exceeds surgical allowance.
 - 247-Duplicate Service.
 - 97-Reimbursement is based on the applicable reimbursement fee schedule.
 - W3-No code description given.
 - 243-Allowance included in another svc.
 - 947-R03-Upheld-No additional allowance has been recommended.

Issues

Are there unbundling issues in this dispute? Is the requestor entitled to additional reimbursement?

Findings

28 Texas Administrative Code §134.203(b)(1) states “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.”

On the disputed date of service, the requestor billed CPT codes 13151-59, 15004 and 99202-25.

- CPT code 13151 is defined as “Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm.”
- CPT code 15004 is defined as “Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children.”
- CPT code 99202 is defined as “Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.”

According to CCI edits, code 13151 is a component of code 15004; however, a modifier is allowed to differentiate the service. The requestor appended modifier 59-Distinct Procedural Service” to CPT code 13151.

“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 operative report does 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;” therefore, the requestor did not support using modifier 59. As a result, no reimbursement is recommended for code 13151.

The respondent contends that “The Carrier reviewed the billing and reimbursed the Provider \$625.18 for CPT code 15004 and denied reimbursement for CPT code 13151 as the Medicare NCCI edits state the two codes are not both entitled to reimbursement without a modifier. The Provider subsequently submitted amended billing, adding modifier-59 to CPT code 13151...The Carrier reviewed the billing and reimbursement for the now primary procedure of CPT code 13151 for the complex surgical repair of the upper lip. The Carrier denied reimbursement for CPT code 15004, however, as the documentation did not support that a separate identifiable procedure, as required for the use of the -59 modifier, had been performed.”

Per 28 Texas Administrative Code §134.203(c)(1)(2), "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. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

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

Place of Service is 11-Office Setting.

The 2013 DWC conversion factor for this service is 55.75.

The Medicare Conversion Factor is 34.023

Review of Box 32 on the CMS-1500 the services were rendered in zip code 79606, which is located in Abilene, Texas; therefore, the Medicare participating amount is based on locality "Rest of Texas".

Using the above formula, the Division finds the following:

Code	Medicare Participating Amount	MAR	Carrier Paid per EOBs	Total Due
13151	\$397.71	\$618.94	\$655.40	Overpayment of \$655.40
15004	\$384.25	\$598.00	\$0.00	\$598.00
99202	\$70.80	\$110.18	\$114.57	Overpayment of \$4.39

Based upon the above, the requestor is not due additional reimbursement.

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

03/27/2015
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).

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