



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Olayinka Ogunro, M.D.

Respondent Name

Indemnity Insurance Company of North America

MFDR Tracking Number

M4-15-2808-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

April 30, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: A review of the submitted documentation finds that a position statement from the requestor was not included.

Amount in Dispute: \$15,810.72

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "According to the requestor, this procedure was for ICD9 Code 715.11. This ICD9 code is for osteoarthritis, a condition not accepted as part of the compensable injury and which is not mentioned in the requestor's pre-authorization request. Accordingly, because this treatment was for a condition not accepted or adjudicated to be part of the compensable injury, reimbursement is improper."

Response Submitted by: The Silvera Firm

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 27, 2015	Shoulder Surgery (29805, 29823-59, 29826-59, 29824-59, 23412-59)	\$15,810.72	\$1713.87

FINDINGS AND DECISION

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

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the guidelines for billing and reimbursing professional medical services.
- The insurance carrier reduced payment for the disputed services with the following relevant claim adjustment codes:
 - 5281 – Non covered services

- 59 – Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
- 78 – The allowance for this procedure was adjusted in accordance with multiple surgical procedure rules and / or guidelines.
- 899 – In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor) component codes of comprehensive surgery: musculoskeletal system procedure (20000-29999) has been disallowed.
- 97 – Payment adjusted because the benefit for this service is included in the payment / allowance for another service / procedure that has already been adjudicated.
- 974 – This procedure is included in the basic allowance of another procedure
- P12 – Workers’ compensation jurisdictional fee schedule adjustment.

Issues

1. Does an unresolved compensability issue exist for this dispute?
2. Are the insurance carrier’s reasons for denial or reduction of payment supported?
3. What is the Maximum Allowable Reimbursement (MAR) for the payable services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. In the position statement, the insurance carrier further states, “this treatment was for a condition not accepted or adjudicated to be part of the compensable injury.” 28 Texas Administrative Code §133.307 (d)(2)(F) states, “The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.” Review of the submitted documentation does not support that an issue of compensability was presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Therefore, this issue will not be considered.
2. The services in dispute are subject to the fee guidelines in 28 Texas Administrative Code (TAC) §134.203, which state,
 - (b) 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 insurance carrier denied disputed CPT Code 29805-LT with claim adjustment reason code “899 – In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor) component codes of comprehensive surgery: musculoskeletal system procedure (20000-29999) has been disallowed;” and “97 – Payment adjusted because the benefit for this service is included in the payment / allowance for another service / procedure that has already been adjudicated.” Per Medicare policy, procedure code 29805, service date February 27, 2015, may not be reported with procedure code 23412 billed on this same claim. A modifier is allowed in order to differentiate between the services provided. Review of the submitted CMS-1500 finds this code included modifier LT, which does not support a separate service. The insurance carrier’s denial reason is supported. Reimbursement for this code is not recommended.

The insurance carrier denied disputed CPT Code 29823-59 with claim adjustment reason code “78 – The allowance for this procedure was adjusted in accordance with multiple surgical procedure rules and/or guidelines;” and “59 – Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.” Per Medicare policy, procedure code 29823, service date February 27, 2015, may not be reported with procedure code 29824 billed on this same claim. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. The CPT Manual provides relevant definition of modifier 59 as follows:

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, separate incision / excision, separate lesion, or separate injury ... 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.

Although the provider billed the service with allowable modifier “-59,” review of the submitted documentation finds that the modifier is not validated. The insurance carrier’s denial reason is supported. Reimbursement for this code is not recommended.

The insurance carrier denied disputed CPT Code 29826-59 with claim adjustment reason code “97 – Payment adjusted because the benefit for this service is included in the payment / allowance for another service / procedure that has already been adjudicated;” and “974 – This procedure is included in the basic allowance of another procedure.” Per Medicare policy, procedure code 29826, service date February 27, 2015, may not be reported with procedure code 23412 billed on this same claim. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. Although the provider billed the service with allowable modifier “-59,” review of the submitted documentation finds that the modifier is not validated. The insurance carrier’s denial reason is supported. Reimbursement for this code is not recommended.

The insurance carrier denied disputed CPT Code 29824-59 with claim adjustment reason code “78 – The allowance for this procedure was adjusted in accordance with multiple surgical procedure rules and / or guidelines.” The *Medicare Claims Processing Manual*, Chapter 12 §40.6 A. 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.” Further, §40.6 B. states,

The following procedures apply when billing for multiple surgeries by the same physician on the same day.

- Report the more major surgical procedure without the multiple procedures modifier “-51.”
- Report additional surgical procedures performed by the surgeon on the same day with modifier “-51.”

Review of the submitted documentation finds that CPT Code 29824 was not the more major surgical procedure and it did not include the modifier “-51.” The insurance carrier’s denial reason is supported. Reimbursement for this code is not recommended.

The insurance carrier denied disputed CPT Code 23412-59 with claim adjustment reason code “5281 – Non covered services.” Review of the submitted documentation, related rules, and Medicare guidelines find that this denial reason is not supported. Therefore, the disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

3. Procedure code 23412, service date February 27, 2015, represents a professional service with reimbursement determined per 28 TAC §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 11.93 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 12.14474. The practice expense (PE) RVU of 10.23 multiplied by the PE GPCI of 1.009 is 10.32207. The malpractice RVU of 2.37 multiplied by the malpractice GPCI of 0.772 is 1.82964. The sum of 24.29645 is multiplied by the Division conversion factor of \$70.54 for a MAR of \$1,713.87.
4. The total allowable for the disputed services is \$1713.87. The insurance carrier paid \$0.00. Reimbursement of \$1713.87 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$1713.87.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1713.87 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	June 12, 2015
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 in accordance with 28 Texas Administrative Code §133.307, 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 MFDR 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.