



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

REGIONAL PLASTIC SURGERY CENTER

Respondent Name

LM INSURANCE CORP

MFDR Tracking Number

M4-16-2894-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

May 20, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not include a position summary with the DWC060 request."

Amount in Dispute: \$2,030.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "24359-XE denied as this is a bundled or non-covered procedure based on Medicare Guidelines; no separate payment allowed...To note, supported CPT is 24358 which is also incidental to 64718. Modifier not supported as done through same incision and documentation does not support separate distinct procedure."

Response Submitted by: Liberty Mutual Insurance Company

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
August 28, 2015	24359-MOD-XE and 20551	\$2,030.00	\$255.73

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 fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - B291 – This is a bundled or non-covered procedure based on Medicare guidelines; no separate payment allowed
 - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly
 - W3 – Additional payment made on appeal/reconsideration
 - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment
 - Z710 – The charge for this procedure exceeds the fee schedule allowance
 - U972 – In accordance with CMS guidelines, this service does not warrant a separate reimbursement
 - X901 – Documentation does not support level of service billed

Issues

1. What are the defenses the insurance carrier raised during the medical bill review process?
2. Did the requestor bill pursuant to 28 Texas Administrative Code §134.203?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor seeks reimbursement for CPT code(s) 20551 and 24359 rendered on August 28, 2015. The insurance carrier denied/reduced the disputed services with denial/reduction code(s) "B291 – This is a bundled or non-covered procedure based on Medicare guidelines; no separate payment allowed, 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly, W3 – Additional payment made on appeal/reconsideration, B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment, Z710 – The charge for this procedure exceeds the fee schedule allowance, U972 – In accordance with CMS guidelines, this service does not warrant a separate reimbursement and X901 – Documentation does not support level of service billed."
2. 28 Texas Administrative Code §134.203 states in pertinent part, "(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 Division completed NCCI edits to identify potential edit conflicts that may affect reimbursement. The following was identified:

Per CCI Guidelines, Procedure Code 64718 has a CCI conflict with Procedure Code 24359 on Claim Line [1]. Review documentation to determine if a modifier is appropriate.

CPT Code 20551: Separate reporting is allowed for the supply code of the drug or substance administered in POS 11 when Procedure Code 20551 is reported. Separate billing is allowed for the supply of injectable materials when an injection is performed in POS 11. Review of the submitted documentation for disputed service code 20551 documents that this service was rendered with place of service code "24", not POS "11", as a result reimbursement cannot be recommended for CPT Code 20551.

CPT Code 24359: Review of the submitted documentation supports that the insurance carrier issued payment for CPT Code 64718, which has a CCI conflict with procedure code 24359 billed on the same date. The insurance carrier did not issue payment for CPT code 24359, which is reimbursable. The Division will determine payment for this procedure code pursuant to 28 Texas Administrative Code §134.203.

The requestor appended modifier -59 to CPT Code 64718. Per CMS, 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."

The requestor's documentation does not meet the documentation requirements for billing modifier -59. As a result, reimbursement is not recommended for CPT Code 64718.

3. 28 Texas Administrative Code §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..."

The MAR reimbursement for CPT Code 24359 is \$1,445.37, minus the previous payment issued by the insurance carrier of \$1,189.64, leaves a recommended amount of \$255.73.

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 \$255.73.

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 \$255.73 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		June 10, 2016
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.