



# 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**

Fondren Orthopedic Group

**Respondent Name**

Ace American Insurance Co

**MFDR Tracking Number**

M4-16-2980-01

**Carrier's Austin Representative**

Box Number 15

**MFDR Date Received**

May 27, 2016

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "These codes were done in separated compartments, procedure code 29822/59 is for debridement that was done for the subscapularis tear and code 29807/59 was for the superior labral repair."

**Amount in Dispute:** \$3,225.06

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Our rationale is as follows: The billed CPT of 29822 and 29807 flag a NCCI Edit when billed with CPT 29806. Per CMS guidelines above, the Modifier 59 was not supported. CMS considers the shoulder joint to be a single anatomic structure. An NCCI procedure to procedure edit code pair consisting of two codes describing two shoulder joint procedures should never be bypassed with an NCCI-associated modifier (ie, Modifier 59) when performed on the ipsilateral (same) shoulder joint. This type of edit may be bypassed only if the two procedures are performed on contralateral joints (opposite shoulder RT vs LT). Liberty Mutual believes that Fondren Orthopedic Group LLP has been appropriately reimbursed for services rendered to (claimant) for the 10/21/2015 date(s) of service."

**Response Submitted by:** Liberty Mutual

#### SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|------------------|-------------------|-------------------|------------|
| October 21, 2015 | 29807,29822       | \$3,225.06        | \$0.00     |

#### 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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - B209 – This procedure is not payable to an assistant surgeon
  - Z710 – The charge for this procedure exceeds the fee schedule allowance
  - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment
  - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
  - X901 – Documentation does not support level of service billed
  - X598 – Claim has been re-evaluated based on additional documentation submitted; no additional payment due

## Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

## Findings

1. The insurance carrier denied disputed services with claim adjustment reason code X901 – "Documentation does not support level of service billed." 28 Texas Administrative Code §134.203 (b) requires that

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;"

Per National Correct Coding Initiative Policy Manual for Medicare Services Chap4-CPTcodes 20000-29999\_final10312014.doc Revision Date: 1/1/2015 Chapter IV Surgery: Musculoskeletal System CPT CODES 20000-29999

### *E. Arthroscopy*

4. *With the exception of the knee joint, arthroscopic debridement should not be reported separately with a surgical arthroscopy procedure...*

Per CMS guidance in regards to correct use of the 59 modifier found at;

<https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/downloads/modifier59.pdf>

**MODIFIER 59 ARTICLE – 1.** *Modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ...*

- *Arthroscopic treatment of structures in adjoining areas of the same shoulder constitutes treatment of a single anatomic site.*

The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

2. Pursuant to Rule 134.203(b)(1) the use of the 59 modifier is not supported. No additional payment is due.

## 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 additional reimbursement for the services in dispute.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
Date

June , 2016

***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.**