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
SOUTH TEXAS RADIOLOGY GROUP

Respondent Name
OHIO CASUALTY INSURANCE CO

MFDR Tracking Number
M4-17-3440-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
JULY 24, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our charge has been denied as bundled with CPT code 20600. We mailed a request for reconsideration with a 59 modifier to separate the 2 codes…Per NCCI a 59 modifier is allowed to separate the 2 codes to allow payment for both."

Amount in Dispute: $52.48

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This is clearly a provider billing error and the carrier has processed the providers billing as submitted allowing only 20600 and denying 76942-26-59 as 1. It is not to be billed in conjunction with 20600 per CPT, 2. There is no indication that there was a separate procedure, so Modifier -59 does not appear appropriate per documentation. Attached for your review is the code description of CPT 20600 and 20604."."

Response Submitted By: Aetna

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 28, 2016	CPT Code 76942-26-59	$52.48	$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, 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 code:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - Z710-The charge for this procedure exceeds the fee schedule allowance.
   - Per CPT, code is denied based on CPT instructions. Service included in 20600.

- 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- W3-Request for reconsideration.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim ws processed properly.

Issues

1. What is the applicable fee guideline?
2. Is the respondent's denial supported?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The fee guidelines for professional services are found in 28 Texas Administrative Code §134.203.

2. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   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: (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."

   On the disputed date of service, the requestor billed the following codes:

   - 20600- Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); without ultrasound guidance; and
   - 76942- Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation.

   Per CCI guidelines code 76942 is included in the allowance of code 20600; however a modifier is allowed to differentiate the service. The requestor appended modifiers "26-Professional Component" and "59-Distinct Procedural Service" to code 76942.

   Modifier 59 is further 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.

   The division finds based upon the code description, CCI edits, the respondent's denial of payment is supported.

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

		8/9/2017
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.