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
ORTHOTEXAS PHYSICIANS AND SURGEONS

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-18-2333-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
MARCH 1, 201816

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT 20606 was denied stating this code billed does not meet the description of the procedure documented. This patient had 2 injections in 2 different parts of the shoulder as a diagnostic tool used by the physician to establish where the patients' pain was coming from. CPT 20606 is supported in dictation showing patient was injected into the proximal biceps tendon sheath. See the attached documentation that supports the services rendered. Please reprocess this claim for payment."

Amount in Dispute: $250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have re-reviewed the physician's procedure report and again found that the CPT code billed 20606-59 is not supported by the documentation."

Response Submitted By: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 20, 2017	CPT Code 20606-RT-59	$250.00	$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 out the reimbursement guidelines for

professional services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 150- Payment adjusted because the payer deems the information submitted does not support this level of service.
   - 263-The code billed does not meet the level/description of the procedure performed/documented. Consideration will be given with coding that reflects the documented procedure.
   - 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.

Issues

Is the requestor entitled to reimbursement for CPT code 20606-RT-59 rendered on July 20, 2017?

Findings

According to the explanation of benefits, the respondent denied reimbursement for CPT code 20606-RT-59 based upon "150- Payment adjusted because the payer deems the information submitted does not support this level of service," and "263-The code billed does not meet the level/description of the procedure performed/documented. Consideration will be given with coding that reflects the documented procedure."

28 Texas Administrative Code §134.203(b) 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…"

On the disputed date of service the requestor billed CPT codes 99214-25, 20611-RT, 73030-RT, 99080-73, 20606-RT-59, S0020 and J0702. Only code 20606-RT-59 is in dispute.

Per CCI edits, CPT codes 20606 and 99214 cannot be billed together; however a modifier is allowed with supporting documentation.

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."

- CPT code 99214 is described as "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. 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 moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family."

- CPT code 20606 is described as "Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting." Modifiers "RT-Right Side" and "59-Distinct Procedural Service" were appended to code 20606. As stated above, code 20606 may be billed with 99214 with a modifier and supporting documentation.

  Modifier 59 is further described 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 E/M report finds the purpose for the visit was "Chief Complaint: right shoulder pain." The injection was for the right shoulder pain. The documentation 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." The division further finds the requestor did not support use of modifier 59; therefore, the respondent's denial of payment is supported.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that 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

		03/20/2018
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.