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
CENTER FOR PAIN RELIEF, PA

Respondent Name
INSURANCE CO OF THE STATE OF PA

MFDR Tracking Number
M4-18-3891-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JUNE 11, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have submitted the documentation to the carrier which is clearly legible for the services provided to this patient on this date of service."

Amount in Dispute: $484.51

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It remains the carrier's position that the provider either did not provide legible information sufficient to reimburse the provider of the provider failed to attach sufficient documentation to support the reimbursement."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 12, 2017	CPT Code 99213-25 Office Visit	$149.46	$0.00
	CPT Code 10140-59 Incision And Drainage Of Hematoma, Seroma Or Fluid Collection	$335.05	$266.91
TOTAL		$484.51	$266.91

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 disputes service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16-Claim/service lacks information or has submission /billing error(s) which is needed for adjudication.
   - 00950-This bill is a reconsideration of a previously reviewed bill, allowance amounts do not reflect previous

payments.

- P12-Workers compensation jurisdictional fee schedule adjustment.
- W3-Request for reconsideration.
- 193-Original payment decision is being maintained. This claim was processed properly the first time.

Issues

Does the documentation support billing CPT codes 99213-25 and 10140-59 on the disputed date of service? Is the requestor entitled to reimbursement?

Findings

The applicable fee guideline for the disputed services is found at 28 Texas Administrative Code §134.203.

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) 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 99213-25 and 10140-59. The respondent denied reimbursement for the services based upon reason code "16-Claim/service lacks information or has submission /billing error(s) which is needed for adjudication," and P12-Workers compensation jurisdictional fee schedule adjustment."

CPT Code 99213

CPT code 99213 is defined 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: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and 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 low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family."

The requestor appended modifier 25 described as "Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service." Modifier 25 is defined as "It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59."

A review of the submitted report finds the requestor did not document at least 2 of the 3 key components for billing 99213; therefore, the requestor is not due reimbursement for this code.

CPT Code 10140-59

CPT Code 10140 is defined as Incision and drainage of hematoma, seroma or fluid collection ."

The requestor appended modifier 59 described as "Distinct Procedural Service." 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. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25."

A review of the submitted report indicates "Aspirated about 30ml serosanguinous material, non-foul sent for culture and sensitivity." The division finds the requestor supported billing CPT code 10140-59. As a result, reimbursement is recommended.

Per 28 Texas Administrative Code §134.203(c)(1)(2), "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 following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2017 DWC conversion factor for this service is 57.5.

The Medicare Conversion Factor is 35.8887

Review of Box 32 on the CMS-1500 the services were rendered in Dallas, Texas.

The Medicare participating amount for code 10140 in Dallas, Texas is $166.59.

Using the above formula, the MAR is $266.91. The respondent paid $0.00. As a result, the requestor is due $266.91.

nclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $266.91.

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 $266.91 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	08/01/2018 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