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
UMC PHYSICIAN NETWORK

Respondent Name
UMC HEALTH SYSTEM

MFDR Tracking Number
M4-18-4378-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
July 16, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We believe modifier -51 billed with 12001 is appropriate to show separate from CPT code 10120-59."

Amount in Dispute: $225.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No response.

Response Submitted by: The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
January 4, 2018	Professional Medical Services: 12001-51	$225.00	$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 sets out the fee guideline for professional medical services.
3. The division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, receipt acknowledged July 25, 2018. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier has not responded. Accordingly, this decision is based on the information available at the time of review.
4. The insurance carrier reduced payment for the disputed service with the following claim adjustment codes:
   - 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.

Issues

Are the insurance carrier's reasons for denial of payment supported?

Findings

This dispute regards a professional service billed under code 12001 (Simple repair of superficial wounds of the extremities; 2.5 cm or less) with reimbursement subject to the *Medical Fee Guideline for Professional Services*, 28 Texas Administrative Code §134.203, requiring the maximum allowable reimbursement (MAR) be determined by applying Medicare payment policies with modifications set out in the rule.

The insurance carrier denied the disputed service with claim adjustment reason code:

- 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.

28 Texas Administrative Code §134.203(b)(1) requires that for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply "Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers . . . and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

Procedure code 12001 has a Medicare correct coding initiative (CCI) edit conflict with procedure code 10120 (simple Incision and removal of foreign body from subcutaneous tissues) that was billed on the same date. The division notes the other service, billed under procedure code 10120, was paid by the insurance carrier. Code 10120 is not listed in the requestor's form DWC060 *Table of Disputed Services*, and is not in dispute.

The CCI edit exists because code 10120 involves incision to remove a foreign body, which includes both wound closure and repair as part of the same service. Thus, the simple repair of superficial wounds described by code 12001 is a lesser service included in the reimbursement for code 10120 and should not ordinarily be unbundled.

However, the CCI edit allows for the provider to bill code 12001 with a modifier in certain circumstances to distinguish a separate service that merits additional payment. Such circumstances include, for example, when the repair is performed at another anatomical site, or during a separate encounter on the same day.

A modifier used to distinguish separate services should accurately reflect the reason that the services are distinct. Additionally, the medical documentation must support the appended modifier to justify separate payment.

After the initial denial, the health care provider resubmitted the claim for reconsideration, this time appending modifier -51 to code 12001. The insurance carrier denied the appeal. The health care provider submitted a second request for reconsideration of the corrected code, but neither the provider nor the insurance carrier presented any EOB or information as to the carrier's determination after reconsideration of the second appeal. Accordingly, the findings and decision in this medical fee dispute are based on the information available at the time of review.

Firstly, modifier -51 (appended to code 12001 by the provider) indicates a subsequent surgery (after the first) that is subject to reduced reimbursement under Medicare's multiple surgery payment reduction rules. Modifier 51 does not describe any specific circumstances or exceptions that would justify overriding this CCI edit.

Secondly, review of the medical records finds the foreign body removal (billed under code 10120) described as "wound irrigation with foreign body removal"—without any documentation of incision that is a prerequisite for the use of that code. The provider documents: "removed asphalt rock from wound. Cleaned and irrigated wound…" (mentioning only a *single* wound) but does not describe where that wound was located, other than the "left lower extremity," which is the same anatomical location as the left knee where the laceration was documented as repaired. Only one wound is referenced, and the diagnosis is indicated as "open wound of left knee." The record does not note any circumstances that would support separate payment or describe in sufficient detail how the services are distinct.

Review of the submitted information finds that modifier -51 is not supported and that the medical record does not sufficiently describe circumstances meriting separate reimbursement or that would justify override of the CCI edit

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

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though not all the evidence was discussed, it was considered.

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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	September 28, 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 Rule §133.307.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.