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
PHYSICIANS SURGICAL CENTER

Respondent Name
HARTFORD UNDERWRITERS INSURANCE CO

MFDR Tracking Number
M4-19-3913-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
APRIL 5, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are requesting that this claim paid in accordance with the 2018 Texas Workers Compensation Fee Schedule and Guidelines for Ambulatory Surgical Centers."

Amount in Dispute: $1,473.07

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Hartford is currently pending additional information from our pricing vendor (Qmedtrix) so that we may provide you with a thorough response."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 13, 2018	Ambulatory Surgical Care Services (ASC) CPT Code 23410	$0.00	$0.00
	ASC Services CPT Code 29822	$1,473.07	$0.00
TOTAL		$1,473.07	$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, effective May 31, 2012 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
    - 851-The allowance was adjusted in accordance with multiple procedure rules and/or guidelines.
    - 983-Charge for this procedure exceeds Medicare ASC schedule allowance.
    - 1115-We find the original review to be accurate and are unable to recommend any additional allowance.
    - P12-Workers' compensation jurisdictional fee schedule adjustment.
    - 983-Charge for this procedure exceeds Medicare ASC schedule allowance.
    - 86-Service performed was distinct or independent from other services performed on the same day.
    - Q97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
    - QS301-This service is included in primary or more extensive procedure.
    - W3-Additional payment made on appeal/reconsideration.

Issues

Is the requestor entitled to reimbursement for ASC services rendered on September 13, 2018?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $1,473.07 for ambulatory surgical care services rendered to the injured worker on September 13, 2018. The fee guidelines for disputed services is found in 28 Texas Administrative Code §134.402.
2. According to the submitted explanation of benefits, the respondent denied reimbursement for CPT code 29822-RT-59 based upon reason code "Q97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated" and "QS301-This service is included in primary or more extensive procedure."
3. 28 Texas Administrative Code §134.402(d) states "For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs."
4. On the disputed date of service, the requestor billed CPT codes 23410 and 29822-RT-59.
5. According to the CCI edits, CPT code 29822 is a component of code 23410; however, a modifier is allowed to differentiate the service. The requestor appended modifier "59-Distinct Procedural Service" to code 29822.
6. 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."
7. A review of the submitted 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." The Division finds that the requestor has not supported the use of modifier "59." As a result, reimbursement is not recommended.

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

Signature	Medical Fee Dispute Resolution Officer	Date
		05/31/2019

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, effective May 31, 2012, *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. **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.