Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
STRUCTURE ORTHOPAEDICS, PLLC

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-20-2105-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
APRIL 30, 2020

REQUESTOR'S POSITION SUMMARY

This is an appeal for partially denied claim dos 01/27/2020. Line item 29105 was denied for bundling. Please see DX code attached to this charge. This is a treatment of a different body part. Line item has AB diagnosis code attached, where are other line items have Dx codes C, F, E or D. We also have an appropriate modifier 59. Please reprocess our claim."

Amount in Dispute: $650.64

RESPONDENT'S POSITION SUMMARY

"Per NCCI edits -reference Chapter 4, (IV-13) G,6 CPT codes for closed, percutaneous, or open treatment of fractures or dislocations include the application of casts, splints, or strapping."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 27, 2020	CPT Code 29105-59-LT	$650.64	$0.00

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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2012 sets out the procedures for resolving a medical fee dispute.
2. 28 TAC §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 208-The application of the initial casting or strapping is included in the value of the visit or procedure.

- DC4-No additional reimbursement allowed after reconsideration.
- CAC-W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 350-Bill has been identified as a request for reconsideration or appeal.
- CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to additional reimbursement for CPT code 29105-59-LT rendered on January 27, 2020?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $650.64 for CPT code 29105-59-LT rendered on January 27, 2020.
2. The fee guidelines for disputed services is found at 28 TAC §134.203.
3. 28 TAC §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."
4. 28 TAC §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."
5. CPT code 29105 is described as "Application of long arm splint (shoulder to hand)."
6. The insurance carrier denied reimbursement based upon codes: 97, 193, W3, DC4, 208, and 350 (defined above).
7. On the disputed date of service, the requestor billed CPT codes 24515-LT, 24341-LT, 23655-LT, 11012-59-LT, 29105-59-LT and 76000-26-59."

   Per CCI edits, CPT code 29105 is a component of codes 24515-LT, 24341-LT, 23655-LT, 11012-59-LT; however, a modifier is allowed to differentiate the service.

   The requestor appended modifier "59-Distinct Procedural Service" and "LT-Left Side" to CPT code 29105.

   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."
8. The Operative report indicates "Placement of left long-arm splint due to associated radial head fracture." The DWC finds the requestor did not support the use of modifier 59, because the procedures were performed at the same session on the left arm and shoulder. The respondent's denial of payment is supported.

Conclusion

For the reasons stated above, the DWC 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 DWC has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		07/09/2020
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, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR 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 DWC. **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.