TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
JASON RICHARD BAILEY, MD

Respondent Name
TRAVELERS CASUALTY & SURETY COMPANY

MFDR Tracking Number
M4-22-1846-01

Carrier's Austin Representative
Box Number 05

DWC Date Received
April 27, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 8, 2021	13132, 64450, 11042 and 29125	$17,809.36	$644.27
	Total	$17,809.36	$644.27

Requestor's Position

"Per EOB received dated 01/28/22 codes 13132, 64450, 11042 and 29125 were denied due to the benefit for this service is included in the payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. We submitted a reconsideration for inferior payment and… re-evaluation denied stating original payment decision is being maintained. All the denied codes per AAPC MCR CCI edits are column 2 codes but you may use a CCI-associated modifier to override the edit under appropriate circumstances. We billed all the denied codes with CCI-associated modifiers. Dr. Ashford has been grossly under-reimbursed for a medically necessary surgery performed…"

Amount in Dispute: $17,809.36

Respondent's Position

"The Carrier has reviewed the documentation and contends the Provider has been reimbursed at the appropriate fee schedule amount. The modifiers billed and cited by the Provider do not change the reimbursement methodology. The Carrier has reviewed the Maximum Allowable Reimbursement Calculation and contends the reimbursement is correct as calculated."

Response Submitted by: Stanford, P.C.

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the fee guideline for professional medical services.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- W3 – Bill is a reconsideration or appeal.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled with the value of another procedure performed.

Issues

1. Is the Insurance Carrier's denial reason(s) supported?
2. Is the Requestor entitled to reimbursement?

Findings

1. The Requestor seeks reimbursement in the amount of $17,809.36 for CPT Codes 13132, 64450, 11042 and 29125 rendered on November 8, 2021. The insurance carrier issued a payment in the amount of $2,681.77 and denied the remaining services with denial reduction codes indicated above.

   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."

   The DWC completed NCCI edits to identify potential edit conflicts that may affect the reimbursement. The following was identified:

Review of the medical bill finds that the Requestor billed CPT Codes 26410 x 2, 13132, 20103, 20520, 64450, 11042 and 29125.

- Per Medicare CCI Guidelines, procedure code 20103 has an unbundle relationship with history procedure code 20520. Review documentation to determine if a modifier is appropriate. The requestor is not seeking dispute resolution for CPT Codes 20103 and 20520.
- Per Medicare CCI Guidelines, procedure code 11042 has an unbundle relationship with history procedure code 20103. Review documentation to determine if a modifier is appropriate. The requestor seeks reimbursement for CPT Code 11042 and appended modifier -59.
- Per Medicare CCI Guidelines, procedure code 11042 has an unbundle relationship with history procedure code 20520. Review documentation to determine if a modifier is appropriate. The requestor seeks reimbursement for CPT Code 11042 and appended modifier -59.
- Per Medicare CCI Guidelines, procedure code 29125 has an unbundle relationship with history procedure code 26410. Review documentation to determine if a modifier is appropriate. The requestor seeks reimbursement for CPT Code 29125 and appended modifier -59.
- Per Medicare CCI Guidelines, procedure code 29125 has an unbundle relationship with history procedure code 11042. Review documentation to determine if a modifier is appropriate. The requestor seeks reimbursement for CPT Code 29125 and appended modifier -59.
- No edit conflicts were identified for CPT Codes 64450 and 13132.

The requestor appended modifier -59 to disputed CPT Codes 29125 and 11042. Modifier -59 is appended, "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…"

Review of the submitted documentation finds that the certain circumstances of when to append modifier -59 is not documented. As a result, the DWC finds that the insurance carrier's denial reason is supported, and the requestor is therefore not entitled to reimbursement for CPT Codes 29125 and 11042.

The DWC finds that the insurance carrier's denial reasons are not supported for CPT Codes 64450 and 13132, as a result, the disputed services are reviewed pursuant to 28 TAC 134.203 (b)(1).

2. 28 TAC §134.203 states in pertinent part, "(c) 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..."

Review of the Medicare payment policies finds the following:

Multiple Surgery/Procedure (Modifier 51) Indicator: 2

Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.

Multiple Surgery/Procedure (Modifier 51) Indicator: 0

No payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure, base payment on the lower of: (a) the actual charge or (b) the fee schedule amount for the procedure.

CPT Code	Multiple Surgery/ Procedure Indicator	CMS Fee Schedule	MAR	Insurance Carrier Paid	MAR After Reduction
*20103	2	$612.01	$1,346.34	-----	-----
13132	2	$503.84	$1,108.38	$0.00	$554.19
*20520	2	$229.14	$504.08	-----	-----
64450	2	$81.90	$180.17	$0.00	$90.08
TOTAL		$1,426.89	$3,138.97		$644.27

*Denotes services not in dispute, however, were included to determine the multiple procedure payment reductions.

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

- The date of service in dispute is November 8, 2021.
- The 2021 Surgery DWC Conversion Factor is 76.76
- The 2021 Medicare Conversion Factor is 34.8931
- Per the medical bills, the services were rendered in zip code 77090; therefore, the Medicare locality is "Houston."
- The Medicare Participating amount for the CPT Codes in dispute is $644.27.
- The Respondent paid $0.00 for the services in dispute.
- The Requestor is therefore entitled to $644.27 for the services in dispute.

The DWC finds that the requestor has established that reimbursement in the amount of $644.27 is due.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The DWC finds the requester has established that reimbursement is in the amount of $644.27 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to additional reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requester the amount of $644.27 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		May 20, 2022
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.