TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
JASON R. BAILEY, M.D., P.A.

Respondent Name
HARTFORD LLOYDS INSURANCE COMPANY

MFDR Tracking Number
M4-22-1981-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
May 12, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 19, 2021	25605, 76000 and 29125	$4,962.62	$45.42
	Total	$4,962.62	$45.42

Requestor's Position

"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 the CCI-associated modifiers. Dr. Ashford has been grossly under-reimbursed for a medically necessary surgery… ."

Amount in Dispute: $4,962.62

Respondent's Position

"Per NCCI Edits: Code 25605 is a column 2 code (inclusive) for code 25608… The provider appended modifier XS – A service that is distinct because it was performed on a separate organ/structure. Additional allowance is due. Code 76000 is a column 2 code (inclusive) for code 25608 and 25605… The provider appended modifier 26-Professional component, which is not an appropriate CCI-associated modifier. No additional allowance is due. Code 29125 is a column 2 code (inclusive) to codes 25608 and 25605. An appropriate CCI-associated modifier 59 was appended to code 29125. However, the cast/splint application is not separately reportable because it is inclusive to the global fracture service. No additional allowance is due. We have processed a reconsideration... to issue the additional allowance of $593.69 for code 25605 (subject to any applicable contracts or discounts.)"

Response Submitted by: The Hartford

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 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:

- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 899 – In accordance with clinical based coding edits (National Correct Coding initiative/outpatient code editor) component codes of comprehensive surgery: Musculoskeletal system procedure (20000-29999) has been disallowed.
- 904 – In accordance with clinical based coding edits national correct coding initiative/outpatient code editor), component code of comprehensive radiology services procedure (70000-79999) has been disallowed.
- 243 – The charge for this procedure was not paid since the value of the procedure is included/bundled within the value of another procedure performed.

Issues

1. Did the insurance carrier issue payment for CPT Code 25605?
2. Are the services in dispute subject to the multiple surgery reduction?
3. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks additional reimbursement for in the amount of $4,962.62, for surgery codes 25605, 76000 and 29125 rendered on November 19, 2021. The insurance carrier states, "We have processed a reconsideration... to issue the additional allowance of $593.69 for code 25605 (subject to any applicable contracts or discounts.)"

   The insurance carrier included a copy of an EOB to support that a payment was issued for CPT Code 25065, as a result, the DWC finds that a payment in the amount of $593.69 was issued and therefore no additional reimbursement is recommended. The DWC now reviews and considers whether the requestor is entitled to reimbursement for CPT Codes 76000 and 29125.

2. The insurance carrier denied/reduced the services in dispute with denial reduction codes indicated above.

28 TAC §134.203 (b) states in pertinent part, "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 reimbursement. The following was identified:

- 25608 – Per Compliance Editor, this charge line did not trigger edits and is considered clean. This requestor does not seek dispute resolution for this CPT Code.
- 25605 – Per Compliance Editor, this charge line did not trigger edits and is considered clean. The insurance carrier issued the MAR reimbursement for this CPT Code. As a result, no additional reimbursement is recommended.
- 29125 – Per Medicare CCI Guidelines, procedure code 29125 has an unbundle relationship with history procedure code 25608. Review documentation to determine if a modifier is appropriate. The requestor appended modifier -59, as a result the requestor is entitled to reimbursement for this code.
- 76000 – Per Medicare CCI Guidelines, procedure code 76000 has an unbundle relationship with history procedure code 25608. The DWC finds that the modifier appended identifies this code as professional service only (-26 modifier). As a result, reimbursement is not recommended.

Review of the Medicare Claims Processing Manual, Chapter 12, 40.6, Claims for Multiple Surgeries defines multiple surgeries as "…separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed. Co-surgeons, surgical teams, or assistants-at-surgery may participate in performing multiple surgeries on the same patient on the same day."

It further states that reimbursement is determined "Base payment for each ranked procedure (indicator '2') on the lower of the billed amount, or:

- 100 percent of the fee schedule amount for the highest valued procedure;
- 50 percent of the fee schedule amount for the second through the fifth highest valued procedure."

Using the formula indicated in 28 TAC §134.203 (c) and the Medicare Claims Processing Manual, Chapter 12, 40.6, Claims for Multiple Surgeries reimbursement is calculated below:

- *25608-RT – 2
  This code contains a status indicator 2
  This code is not subject to the multiple procedure rule discounting as it has the highest RVU, 100% reimbursement.
- 25605-RT-XS
  This code contains a status indicator 2
  This code is subject to the multiple procedure rule discounting of 50%.

- 29125-59
  This code contains a status indicator 2
  This code is subject to the multiple procedure rule discounting of 50%.

(* - This CPT Code is not in dispute, however, is included to identify edit conflicts that may affect reimbursement.)

3. 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 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…"

   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 is November 19, 2021.
   - The 2021 DWC Surgery 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 Texas."

   The Medicare Participating amount for CPT code 25605 at this locality is $539.75.
   - Using the above formula, the DWC finds the MAR is $1,187.38 after the 50% reduction the recommended amount is $593.69.
   - The respondent paid $593.69.
   - Reimbursement of $0.00 is recommended.

   The Medicare Participating amount for CPT code 29125 at this locality is $41.30.
   - Using the above formula, the DWC finds the MAR is $90.85 after the 50% reduction the recommended amount is $45.42.
   - The respondent paid $0.00.
   - Reimbursement of $45.42 is recommended.

4. The total recommended amount is $45.42. The requestor is entitled to additional reimbursement in the amount of $45.42.

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 of $45.42 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor $45.42 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 9, 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. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

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).

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.