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
Bailey, Jason Richard

Respondent Name
Merkel Insurance Co

MFDR Tracking Number
M4-23-0162-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
September 19, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 3, 2022	11012,13132,20103, 11010,12013,64450, 29125	$16,572.29	$0.00
	Total	$16,572.29	$0.00

Requestor's Position

"Please review the documents attached. I am also submitting a copy of the AAPC CCI Edits show that all denied codes are column 2 codes but you may use a NCCI-associated modifier to override the edit under appropriate circumstances. We billed all denied codes with CCI-associated modifier 59."

Amount in Dispute: $16,572.29

Respondent's Position

"Please see the EOBs included in the Requestor's DWC-60. The Carrier has paid a total of $5,463.58 for the entire surgery. Documentation did not support the separate reimbursement of any other changes, even when adding the -59 modifier. In conclusion, Requestor is not owed any additional reimbursement for the surgical procedure."

Response submitted by: Downs 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 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.203 sets out the fee guidelines for professional services.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- P12 – Workers' compensation jurisdiction fee schedule adjustment
- 790 – This charge was reimbursed in accordance to the Texas medical fee guideline
- 329 – Allowance for this service represents 50% because of multiple or bilateral rules
- 59 – Distinct service
- 252 – An attachment / other documentation is required to adjudicate this claim/service
- 435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure
- 236 – This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the NCCI or Workers Compensation State Regulations / Fee schedule requirements
- D50 - Documentation does not support this code for reimbursement. Results of professional review (RN, MD, DC, CPC, or other medical professional)
- 423 – CCI edits for this code have not been applied at payer's discretion
- B22 – This payment is adjusted based on the diagnosis

Issues

1. Is the insurance carrier's denial supported?

2. What rule is applicable to reimbursement?

3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of professional services rendered in May of 2022, submitted with the following codes.

    - 11012 - Debridement including removal of foreign material at the site of an open

fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, muscle, and bone. Billed with 59 modifier.

- 13132 - Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm. Billed with 59 modifier.
- 20103 - Exploration of penetrating wound (separate procedure); extremity. Billed with 59 modifier.
- 11010 - Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin and subcutaneous tissues. Billed with 59 modifier.
- 12013 - Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin and subcutaneous tissues. Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm. Billed with 59 modifier.
- 64450 - Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch. Billed with 59 modifier.
- 29125 - Application of short arm splint (forearm to hand); static. Billed with 59 modifier.

DWC Rule 28 TAC §134.203 Medical Fee Guideline for Professional Services, states:

(a) (5) "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.

(b) 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 insurance carrier denied the disputed codes based on Medicare's NCCI edits. The requestor states in their position statement they billed with the 59 modifier.

The 59 modifier is described 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."

Review of the submitted explanation of benefits found the insurance carrier paid as follows:

- Code 26356-ET/Repair finger/hand tendon, carrier paid $1,894.67
- Code 26356-ET/Repair finder/hand tendon, carrier paid $947.34
- Code 26418-ET/Repair finger tendon, carrier paid $761.13
- Code 26735 -ET/Treat Finger Fracture, each carrier paid $708.30
- Code 26755-ET/Treat finger fracture, each, carrier paid $330.60
- Code 64831-ET/Repair of digit nerve, carrier paid $821.54

Review of the NCCI edits at www.cms.gov NCCI for Medicare | CMS, found multiple edits.

Addition of the 59 modifier does not guarantee payment. Rather the 59 modifier is used to indicate documentation exists to support an exception to the NCCI edit.

Review of the submitted documentation found did 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 submitted operative report indicates the insurance carrier paid the primary procedure and denied the services that are bundled into the primary payment.

No additional payment is recommended.

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.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 15, 2022 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.