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

General Information

Requestor Name
Jason R. Bailey, M.D. PA

Respondent Name
ACE American Insurance Co.

MFDR Tracking Number
M4-23-0299-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
October 4, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 12, 2022	CPT 13132-ET-XS and 64450-ET-59	$4,177.40	$0.00

Requestor's Position

... all denied codes are column 2 codes but you may use a NCCI-associated modifier to override the edit under appropriate circumstances. We billed both codes with CCI-associated modifiers 59 and XS.

Amount in Dispute: $4,177.40

Respondent's Position

With respect to the two CPT codes, 13132 is for wound closure which is global to CPT code 26474 and is not to be billed separately. With respect to CPT code, 64450, it is for post-op pain management which is also considered global to CPT code 26474. No additional reimbursement is allowed. The provider is not entitled to any additional payment.

Response Submitted by: Flahive, Ogden & Latson

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 §133.307 sets out the procedures for resolving medical fee disputes.

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

Denial Reasons

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

- 00663 – Reimbursement has been calculated according to state fee schedule guidelines
- 90121 – Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
- 59 – Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
- 97 – The Benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 4063 – Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting.

Issues

1. Is ACE American Insurance Co.'s denial supported?

Findings

1. Jason R. Bailey, M.D. PA is seeking reimbursement for procedure codes 13132 and 64450. Procedure code 13132 is defined as "Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm." Procedure code 64450 is defined as "Injection(s), anesthetic agent(s)and/or steroid; other peripheral nerve or branch."

   The insurance carrier denied payment stating, in part, "Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules," and "The Benefit for this service is included in the payment/allowance for another service/ procedure that has already been adjudicated."

   Dr. Bailey also billed procedure code 26474, which is defined as "Tenodesis; of distal joint, each joint." Per CMS, the codes in question may not be billed with this code. A modifier is allowed

to identify a service as distinct from the procedure.

Dr. Bailey billed procedure code 13132 with modifier XS. CMS defines modifier XS with the following: "Separate Structure, A service that is distinct because it was performed on a separate organ/structure."

No evidence was found to support that a repair was performed on a different organ or structure. DWC finds that ACE American Insurance Co.'s denial of payment for this code is supported.

Dr. Bailey billed procedure code 64450 with modifier 59. CMS defines modifier 59 with the following:

> Distinct Procedural Service: 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. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non E/M service performed on the same date, see modifier 25.

Documentation submitted does not support that billed code 64450 was a distinct procedural service from billed code 26474. DWC finds that ACE American Insurance Co.'s denial reason is supported for this billed code.

No reimbursement is recommended for the services in question.

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	November 17, 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.