



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Surgery Specialty Hospitals of America SE

Respondent Name

Insurance Co of the State of PA

MFDR Tracking Number

M4-23-0528-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

October 27, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 7, 2022	63635-50 (sic)	\$1,779.65	\$0.00
	Total	\$1,779.65	\$0.00

Requestor's Position

"The Carrier did not make payment according to the Bilateral Procedure reimbursement rate. Modifier "50" is used for bilateral procedures which are procedures performed on both sides of the body during same operative sessions. These procedures are to be paid at 150% of the Medicare Fee Schedule."

Amount in Dispute: \$1,779.65

Respondent's Position

"The Provider contends they are entitled to additional reimbursement due to the bilateral nature of the procedure performed. CPT code 64635 (incorrectly identified in the Table of Disputed Services as 63635). As documented in the Provider's Request, CPT code 63635 is a J1 code... Codes designated as J1 status are exempt from the use of the -50 modifier for bilateral designation. Consequently, as a J1 status code, CPT code 64635 is not eligible for bilateral

reimbursement.”

Response submitted by: Constitution State Services

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 §134.403 sets out the fee guidelines for outpatient hospital services.

Denial Reasons

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

- P12 – Workers’ compensation jurisdictional fee schedule adjustment
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

Issues

1. What rule applies for determining reimbursement for the disputed services?

Findings

1. The requestor is seeking additional reimbursement of APC 5431 (CPT code 64635) based on application of “50” modifier to indicate bilateral procedure.

DWC Rule 28 TAC §134.403 (d) requires Texas workers’ compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.1. Specifically, Payment Status Indicators and Ambulatory Payment Category (APC).

Review of the assigned APC for CPT code is 5431. Appendix A of the annual OPSS files lists APC 5431 as J1 status indicator or Composite APC.

The Medicare Claims Processing Manual Section 10.2.1 - Composite APCs states in pertinent part, *“Composite APCs provide a single payment for a comprehensive diagnostic and/or treatment service that is defined, for purposes of the APC, as a service typically reported with multiple HCPCS codes. When HCPCS codes that meet the criteria for payment of the composite*

APC are billed on the same date of service, CMS makes a single payment for all of the codes as a whole, rather than paying individually for each code."

Based on the above, the insurance carrier's reduction is supported, 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

_____	_____	November 21, 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 electrónico CompConnection@tdi.texas.gov.