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 RICHARD BAILEY MD PA

Respondent Name
SENTRY SELECT INSURANCE COMPANY

MFDR Tracking Number
M4-23-1237-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
January 30, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 3, 2022	13132, 20103, 12042, 76000 and 29125	$8,686.40	$0.00
	Total	$8,686.40	$0.00

Requestor's Position

"Our claim was processed and paid a partial reimbursement of $5,045.15. EOBs received show CPT codes 13132, 20103, 12042, 76000 and 29125 denied due to payer deems the information submitted does not support this level of service... Based on the information provided, I am requesting that this claim be reviewed and reprocessed accordingly: it should allow correct payment for the denied codes for EMERGENT surgery."

Amount in Dispute: $8,686.40

Respondent's Position

"...the documentation did not support reporting or separately reimbursing for codes 20103, 29125, 13132, 12042, and 76000. Appending modifier 59 was inappropriately applied. Optum does not dispute the need for treatment and did not dispute payment based on medical necessity of services but rather on the correct coding and reporting. Optum would ask the Division of Workers' Compensation to uphold the original determination of denial of reimbursement."

Response Submitted by: Optum

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:

- 18 – EXACT DUPLICATE CLAIM/SERVICE.
- W3 - IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 150 - THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE.
- 193 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- NOTE: Audit upheld. CPT 29125 is bundled per NCCI edits to CPT 26776 per CPT Coding Instructions. CPT 13132 is bundled into 11012 per CPT coding instructions. CPT 12042 Is bundled into CPT 64831 & 26410 per Column 1/2 edits. The service submitted is not supported based on the AMA and CMS criteria for Modifier 59.
- CCL: THIS BILL WAS REVIEWED BY A SPECIALTY AUDIT/CODING EXPERT BY APPLYING CODE AUDITING RULES AND EDITS BASED ON CODING CONVENTIONS DEFINED BY AMA AND CODING GUIDELINES DEVELOPED BY NATIONAL SOCIETIES AND PREVAILING INDUSTRY STANDARDS AND CODING PRACTICES.
- CPT 76000 - CPT code is a (separate procedure) and requires a separate detailed written report to be considered for payment. The addition of modifier XU is not appropriate without a detailed written report. Per AMA CPT radiology guidance, June 2008 CPT Assistant article on fluoroscopy coding, The American College of Radiology and ACR Bulletin, Update on Fluoroscopy Coding, March 2002. CPT 29125 · Bundled per NCCI edits to CPT 26776 per CPT Coding instructions. CPT 13132 is bundled into 11012 per CPT Coding instructions. CPT 12042 Is bundled into CPT 64831 & 26410 per Column 1/2 edits. CPT 20103 is a defined as a separate procedure per AMA/CPT and some of the procedures or services listed in CPT are commonly carried out as an integral component of a total service or procedure and have been identified by the inclusion of the term (separate procedure). The codes designated as such should not be reported in addition to the code for the total procedure or service of which it is considered an integral component.

Issues

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

Findings

1. The requestor seeks reimbursement for CPT codes 13132, 20103, 12042, 76000 and 29125 rendered on May 3, 2022. The insurance carrier denied/reduced the disputed 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 if the disputed services rendered on May 3, 2022 contain edit conflicts that may affect reimbursement.

   The requestor billed the following CPT codes on May 3, 2022: 13132-ET-59, 20103-ET-59, 12042-ET-59, 76000-ET-59, 29125-ET-59, 26356-ET, 26410-ET, 11012-ET-59, 26727-ET, 64831-ET, and 26776-ET.

   CPT Codes 13132-ET-59, 20103-ET-59, 12042-ET-59, 76000-ET-59, and 29125-ET-59 are currently in dispute the remaining services were reimbursed by the insurance carrier and not in dispute:

   - CPT Code 13132 is described as, "Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm."
   - CPT Code 20103 is described as, "Exploration of penetrating wound (separate procedure); extremity."
   - CPT Code 12042 is described as, "Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.6 cm to 7.5 cm."
   - CPT Code 76000 is described as, "Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time."
   - CPT Code 29125 is described as, "Application of short arm splint (forearm to hand); static."
   - Modifier -ET is described as, "Emergency services."
   - Modifier -59 is described as, "Distinct Procedural Service."

   The DWC finds the following:

   - CCI conflict code 11012 (Column 1) conflicts with code 12042 (Column 2).
   - CCI conflict code 26727 (Column 1) conflicts with code 13132 (Column 2).
   - CCI conflict code 26410 (Column 1) conflicts with code 12042 (Column 2).
   - CCI conflict code 11012 (Column 1) conflicts with code 20103 (Column 2).
   - CCI conflict code 26727 (Column 1) conflicts with code 76000 (Column 2).
   - CCI conflict code 29125 (Column 1) conflicts with code 12042 (Column 2).

The requestor appended modifier -59 to all of the services in dispute.

The description and application of the -59 modifier is addressed in the CMS MLN1783722 March 2022. The CPT Manual defines modifier fifty-nine as follows:

"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 (Evaluation/Management) 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."

The DWC finds that the insurance carrier's denial reasons are supported and therefore, the requestor is not entitled to reimbursement for the services in dispute.

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 not established that reimbursement is due.

Order

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

Authorized Signature

		April 10, 2023
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.