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. PA

Respondent Name
Sunz Insurance Co.

MFDR Tracking Number
M4-23-2866-01

Carrier's Austin Representative
Box Number 20

DWC Date Received
July 13, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
01/11/2023	11012, 13132, 29125	$7,698.90	$651.28
	Total	$7,698.90	$651.28

Requestor's Position

"Our claim was processed and paid a partial reimbursement of $4,410.27. EOB received show CPT codes 13132, 11012 and 29125 denied due to payment is included in the allowance for another service/procedure… We submitted a reconsideration on 4/5/23 with documentation and received a denied EOB…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: $7,698.90

Respondent's Position

"CPT codes 29125, 11012 and 13132 have been denied by the carrier as mutually inclusive to other services rendered to the injured worker. The provider bill modifier 59 to override NCCI edits and AAOS guidelines. Unfortunately, the medical report does not support modifier 59 as these services are not a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury."
Response Submitted by: CompIQ 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 Texas Administrative Code (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 denied payment for the disputed services with the following claim adjustment codes:

- 811 – Modifier -59 for Distinct Procedural Service is not reimbursable as it is not supported by the submitted documentation.
- 947 - The billed service is not substantiated by the medical notes/report.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- N1- Not supported per the documentation.
- 14 – Payment is included in the allowance of another procedure and is not separately reimbursable.
- P14 - The benefit for this service is included in the payment/allowance for another service/procedure that has been performed on the same day.
- AIQ100 – This bill has been reviewed by an AuditIQ Certified Coder. Denials/reductions are based on the application of code auditing rules defined in the AMA CPT manual and coding guidelines developed by national societies and prevailing industry coding practices.

Issues

1. Is the Insurance Carrier's denial reason(s) for disputed CPT codes 13132 and 29125 rendered on January 11, 2023, supported?
2. Is the Insurance Carrier's denial reason(s) for disputed CPT code 11012 rendered on January 11, 2023, supported?
3. Do the disputed services contain National Correct Coding Initiative (NCCI) edit conflicts that may affect reimbursement?
4. Is the Requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied reimbursement for disputed CPT codes 13132 and 29125 rendered on January 11, 2023, based on absence of documentation to support the use of Modifier -59.

    - Modifier -59 is described as a "Distinct Procedural Service" 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.

    The CPT codes in dispute are related to surgery services and are described as follows:

    - CPT 13132 - Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm.
    - CPT 29125 - Application of short arm splint (forearm to hand); static.

    The insurance carrier denied CPT codes, 13132 and 29125, which were appended with modifier -59, for reason code 811: "Modifier -59 for Distinct Procedural Service is not reimbursable as it is not supported by the submitted documentation". Review of medical documentation submitted finds that CPT codes 13132 and 29125 were performed during the same surgical session, to the same anatomic site and for the same injury. Therefore, DWC finds that medical documentation submitted does not support the use of Modifier -59 in the billing of CPT codes 13132 and 29125.

    DWC finds that the insurance carrier's denial reason of CPT codes 13132 and 29125, appended with modifier -59, is supported.

2. The insurance carrier denied CPT code 11012, rendered on January 11, 2023, using reason codes which state that the service is not substantiated or supported by the medical notes/report/documentation.

    CPT code 11012 is described as - Debridement, including removal of foreign material at the site of an open fracture and/or an open dislocation (e.g., excisional debridement); skin, subcutaneous tissue, muscle fascia, muscle, and bone.

    Review of submitted medical report finds that the procedure of wound debridement is documented in both the list of procedures performed as well as in the narrative description of the operative report. Therefore, DWC finds that the insurance carrier's denial reasons of CPT code 11012 are not supported.

3. 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 determine if any edit conflicts may affect reimbursement.

The requestor billed the CPT Codes noted below on disputed date of service January 11, 2023. The following was found, (CPT codes in dispute are in bold):

11012 – No NCCI edit conflicts found

13132 – No NCCI edit conflicts found

29125 – No NCCI edit conflicts found

26540 – No NCCI edit conflicts found

26591 – No NCCI edit conflicts found

26418 – No NCCI edit conflicts found

64831 – No NCCI edit conflicts found

99223 – No NCCI edit conflicts found

69990 – Bundled relationship with CPT codes 26540, 11012, 26418, 26591, 29125

The disputed CPT Codes 11012, 13132, and 29125 contained no NCCI edit conflicts with the CPT Codes billed on the same day.

4. The requestor seeks reimbursement in the total amount of $7,698.90 for CPT codes 11012, 13132, and 29125, rendered on January 11, 2023.

   Because the denial reason of CPT codes 13132 and 29125 was supported, DWC finds that the requestor is not entitled to reimbursement for those disputed services.

   Because the denial reasons of CPT code 11012 were not supported, DWC finds that the requestor is entitled to reimbursement for this service. Therefore, the reimbursement for CPT code 11012 will be adjudicated and calculated below according to the applicable rules and fee guidelines.

   Review of the Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, section 40.6 - Claims for Multiple Surgeries, CMS 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. Per CMS, multiple surgeries are reimbursed as follows:

   - 100 percent of the fee schedule amount (Field 34 or 35) for the highest valued procedure; and
   - 50 percent of the fee schedule amount for the second through the fifth highest valued procedures

   Medicare pays for multiple surgeries by ranking from the highest Medicare Physician Fee Schedule (MPFS) amount to the lowest MPFS amount. When the same physician performs

more than one surgical service at the same session, the allowed amount is 100% for the surgical code with the highest MPFS amount. The allowed amount for the subsequent surgical codes is based on 50% of the MPFS amount. To determine which surgeries are subject to the multiple surgery rules, the rank assigned by Medicare is reviewed for each surgery code.

CPT code 11012 has a status indictor of 2, which represents "standard payment adjustment rules for multiple procedures apply." **The multiple procedure payment reduction (MPPR) applies; therefore, appropriate reimbursement is 50% of the MAR.**

28 TAC §134.203 states in pertinent part, "(c) To determine the maximum allowable reimbursement (MAR) for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. 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..."

CPT code 11012, rendered on January 11, 2023, represents a professional service with reimbursement determined per §134.203(c).

To determine the MAR the following formula is used:
(DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = MAR

- The 2023 DWC Conversion Factor is 64.83
- The 2023 Medicare Conversion Factor is 33.8872
- Per the medical bills, the services were rendered in zip code 77090; therefore, the Medicare locality is 18, Houston.
- The Medicare Participating amount for CPT code 11012 at this locality in 2023 is $680.85. Fifty percent of MPFS = $340.43
- Using the above formula, the DWC finds the MAR is $651.28.
- The respondent paid $0.00.
- Reimbursement of $651.28 is recommended.

DWC finds that reimbursement in the amount $651.28 is due for CPT code 11012 rendered on January 11, 2023.

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 additional reimbursement is due in the amount of $651.28.

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 Sunz Insurance Co. must remit to Jason R. Bailey, M.D. PA $651.28 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		September 15, 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 managing 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.