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
Lankford Hand Surgery Assn.

Respondent Name
LM Insurance Corp

MFDR Tracking Number
M4-23-3161-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
August 14, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 22, 2023	99203	$220.48	$0.00
February 22, 2023	10060	$247.90	$0.00
February 22, 2023	J2001	$9.00	$0.00
	Total	$477.38	$0.00

Requestor's Position

No position statement submitted by the requestor.

Amount in Dispute: $477.38

Respondent's Position

"LM Insurance Corp finds that payment should be made for CPT code 10060. Additional payment will be made for this procedure per the Texas Fee Schedule allowance. ...Evaluation and Management service that becomes the decision for surgery on the day of the surgery procedure including the history and physical, local infiltration of block or topical anesthesia, evaluating the patient postoperatively, and other services. CPT code 10060 has global days of 10 (minor procedure). This code has a CMS CCI conflict with J2001. ...The office visit documentation received only supports services that are included in the pre, intra, and post operative care of the

minor procedure performed. The documentation received by the provider does not support the usage of modifier 25, nothing was separate, distinct, above, and beyond to warrant billing the E/M code or the modifier 25. NCCI advises that payment of surgical procedures packages the payment of supplies, dressing, and local anesthesia into the surgical procedure. These items are not separately reportable under their own HCPCS/CPT code."

Response submitted by: Liberty Mutual Insurance

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 billing and coding guidelines for durable medical equipment.

Denial Reasons

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

- 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
- 5845 – No significant identifiable evaluation and management service has been documented.
- 275 – The charge was disallowed; as the submitted report does not substantiate the service being billed.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 48 – The provider billed for a visit on the same day of surgery or within the follow-up of a previously performed surgery.

Issues

1. What services are in dispute?
2. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement of professional medical services rendered in February of 2023. The following codes are listed on the DWC060 as in dispute.

    - 99203-25, Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
    - 10060 – Incision and drainage of abscess.
    - J2001 – Injection, lidocaine HCI for intravenous infusion.

    The insurance carrier denied Code 99203 -25 as billed on same day of surgical procedure. The use of the 25 modifier was disallowed as documentation did not support separate and distinct service.

    The insurance carrier paid $245.53 for Code 10060 on August 29, 2023. This is more than requested. No additional payment recommended.

    The insurance carrier denied Code J2001 as being packaged.

2. DWC Rule 28 TAC §134.203 (b)(1) states in pertinent parts, for coding billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifier…

    Review of the Medicare National Correct Coding Initiative Policy Manual, Chapter Four, Section B states in pertinent part, *In general, E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and shall not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25*.

    The 25 modifier is defined as *It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.*

    Review of the submitted "Encounter Report" indicates the claimant was seen and it was determined that removal of the dressing was required but due to the chance of pain a digital block was performed. The physician noted drainage and the need for a revision amputation.

    Based on this review insufficient evidence was found to support the E/M service was unrelated to the decision to perform the minor surgical procedure. The insurance carrier's denial is supported. No payment is recommended.

Regarding anesthesia. The NCCI manual, Section I (5) states, *With few exceptions, the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes.*

No payment is recommended for Code J2001.

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 entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 14, 2023 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.