TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Peter E Grays MD

**Respondent Name**
Travelers Indemnity Co

**MFDR Tracking Number**
M4-12-1354-01

**Carrier's Austin Representative**
Box Number 05

**MFDR Date Received**
January 3, 2012

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Without this surgical excision of the spermatic cord lipoma the patient would most likely require future surgical consultations and possible surgery due to prolong abdominal and groin pain. The patient's recovery would have been negatively impacted without this surgical service."

**Amount in Dispute:** $677.44

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "As documented by the operative report included in the Provider's Request for Medical Fee Dispute Resolution, this was clearly not a separate incision or surgical sight, and was part of the hernia repair surgical sight during the same procedure."

**Response Submitted by:** Travelers

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| March 24, 2011 | 55520 | $677.44 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - W1 – Workers compensation state fee schedule adjustment
   - 97 – Payment is included in the allowance for another service/procedure

**Issues**

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

**Findings**

1. The insurance carrier denied disputed services with claim adjustment reason code 97 – "Payment is included in the allowance for another service/procedure." 28 Texas Administrative Code §134.203 (b) "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;."

   Review of the submitted information finds that the service in dispute is for Codes;

   - 55520 -59, RT - Excision of lesion of spermatic cord (separate procedure)

   Code 55520 is described as a separate procedure by definition but is usually a component of a more complex service and is not identified separately. The "59" modifier 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. Review of the submitted "Operative Report" finds insufficient information to support a different session, site or organ system, or separate incision/excision or that the service in dispute is not ordinarily encountered or performed on the same day by the same individual.

   The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

2. Per the above no additional payment can be recommended as the requirements of 134.203 (b) were not met.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| | | |
|---|---|---|
| | | September , 2015 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MFDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of this *Medical Fee Dispute Resolution Findings and Decision***, together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.