TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
JASON BAILEY, MD, PA

Respondent Name
STANDARD FIRE INSURANCE COMPANY

MFDR Tracking Number
M4-23-1856-01

Carrier's Austin Representative
Box Number 05

DWC Date Received
March 30, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 13, 2022	13131, 64450, and 11730	$4,075.28	$445.23
	Total	$4,075.28	$445.23

Requestor's Position

"Our claim was processed and denied incorrectly. Per EOB, received code(s) 11012, 13131, 64450, 11730, and 76000 denied due to: Bundling, which should be overturned as we have included the appropriate modifiers according to the attached NCCI edits. I am attaching a copy of Dr. Bailey's OP report along with the consultation on 09/13/22 dictating the work injury. We are able to bill these codes with the modifiers used without bundling."

Amount in Dispute: $4,075.28

Respondent's Position

"The Provider contends that by appending the -XS modifier (separate structure) to CPT code 13131 and the -59 modifier (distinct procedural service) to CPT codes 64450 and 11730 they have appropriately documented these services were separate from the related primary services billed on the same date. Under the NCCI edits, CPT codes 13131 and 64450 are included with CPT code 26765 (repair of fracture of hand/finger), and CPT code 11730 is included in CPT code 11760 (surgical repair of nail). Reimbursement for the primary CPT codes (26765 and 11760) include reimbursement for the secondary CPT codes."

Response Submitted by: Travelers

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

- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- W3 – Bill is a reconsideration or appeal.
- 1014 – The attached billing has been reevaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 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.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 59 – Charges are adjusted based on the multiple surgery rules or concurrent anesthesia rules.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 4063 – Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting.
- 78 – The allowance for this procedure was adjusted in accordance with multiple surgical procedure rules and/or guidelines.
- 86 – Service performed was distinct or independent from other services performed on the same day.

Issues

1. What are the services in dispute?
2. Do the disputed services contain edit conflicts that could have an impact on reimbursement?
3. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT codes 13131, 64450, and 11730, rendered on September 13, 2022. The insurance carrier issued a payment in the amount of $2,672.52 for CPT codes that are not in dispute and denied the disputed services due to the multiple surgical procedure rules and/or guidelines.

   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 examined any potential edits that may conflict and would have an impact on reimbursement. A review of the medical bills finds that the requestor billed the following CPT codes on September 13, 2022: 99223, 11012, 26765, 20103, 13131, 11760, 64450, 11730, and 76000. The requestor is only seeking reimbursement for CPT codes 13131, 64450, and 11730. Therefore, these codes will be reviewed pursuant to the applicable rules and guidelines.

   CPT Code 13131-ET-XS is described as, "Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm."

   CPT Code 64450-ET-59 is described as, "Injection(s), anesthetic agent(s) and/or steroid, other peripheral nerve, or branch.

   CPT Code 11730-ET-59-F2 is described as, "Avulsion of nail plate, partial or complete, simple; single."

   The requestor appended the following modifiers.

   ET –Emergency services

   59 - Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M 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.

   F2 – Left hand, third digit

   XS - Separate structure, a service that is distinct because it was performed on a separate organ/structure.

2. The DWC completed NCCI edits and determined no edit conflicts that could have an impact on reimbursement. As a result, the requestor is entitled to reimbursement based on the multiple procedure rules.

   A review of the Medicare payment policies finds the following:

   Multiple Surgery/Procedure (Modifier 51) Indicator: 2

   Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.

   Multiple Surgery/Procedure (Modifier 51) Indicator: 0

   No payment adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure, base payment on the lower of: (a) the actual charge or (b) the fee schedule amount for the procedure.

   A 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 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, you review the rank assigned by Medicare for each surgery code.

   Multiple Surgery/Procedure (Modifier 51) Indicator: 2

   Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.

The DWC finds that, "Base payment for each ranked procedure code on the lower of the billed amount: 100% of the fee schedule amount for the highest valued procedure; and 50% of the fee schedule amount for the second through the fifth highest valued procedure."

The Division finds that the three CPT codes in dispute are subject to the MPPR reduction and are reimbursed at 50% of the fee guideline.

3. 28 TAC §134.203 states in pertinent part, "(c) To determine the 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..."

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

   - The 2022 Surgery DWC Conversion Factor is 78.37
   - The 2022 Medicare Conversion Factor is 34.6062
   - Per the medical bills, the services were rendered in zip code 77598; the Medicare locality is "Houston, 4412-18."

CPT Code	Multiple Surgery Procedure Indicator	CMS Fee Schedule	MAR	Insurance Carrier Paid	MAR after 50% Reduction
13131	2	$249.92	$565.97	$0.00	$282.99
64450 x 2	2	$43.83	$99.26 (x2)	$0.00	$99.26
11730	2	$55.62	$125.96	$0.00	$62.98
	TOTAL	$349.37	$791.19	$0.00	$445.23

The DWC finds that the requestor is entitled to reimbursement in the amount of $445.23.

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 reimbursement of $445.23 is due.

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 the Respondent must remit to the Requestor $445.23 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		September 17, 2024
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.