MDR: M4-02-2544-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $2407.50 for date of service, 07/12/01.

   b. The request was received on 03/05/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFA(s)
   c. EOB/TWCC 62 forms/Medical Audit summary
   d. Redacted example EOBs from other insurance carriers
   e. Medical Records
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. Response to a Request for Dispute Resolution
   b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 05/07/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 05/13/02. The response from the insurance carrier was received in the Division on 05/17/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of A letter Requesting Additional Information is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 05/07/02

   "…We are requesting you [sic] help in resolving this fee dispute for the above mentioned issue… We feel we have billed these procedures fair and reasonable and they should be reimbursed in full according to documentation and other insurance carrier's EOB's [sic] that are enclosed… The codes in the table that are listed in the TWCC fee guidelines were all coded and billed exactly correct according to the TWCC fee guidelines We feel that the insurance carriers [sic] reasons for non-payment of these services cannot be justified."

2. Respondent: Letter dated 03/08/02

   "We have received notice of the dispute filed by (Requestor) for date of service: 7/12/01, CPT codes 22899-51, 22899-51, 27299-51, 64714-51, 22899-51. The bill and attached documentation have been carefully re-reviewed and our position remains the same. The rationale used for payment is as follows:
   CPT 22899-51 Billed: 1 @ $1200.00 Paid: 1 @ $1000.00 100% Fair and Reasonable for cage #1
   CPT 22899-51 Billed: 1 @ $1200.00 Paid: 1 @ $1000.00 100% Fair and Reasonable for cage #2
   CPT 27299-51 Billed: 1 @ $850.00 Paid: 0 Denied as global.
   The provider used this code to represent reconstruction of iliac crest. This was denied as global per the 1994 American Academy of Orthopaedic Surgeons Global Service Data Handbook (AAOS) pg. V. #9…
   CPT 64714-51 Billed: 1 @ $657.50 Paid: 0 Denied as global to 63042.
   CPT 22899-51 Billed: 1 @ $500.00 Paid: 0 Denied as global
   The providers [sic] rationale is the surgeon uses the patients [sic] posterior element bone mixed with 15cc of pro-osteon granules. The letter states this is a separate procedure…. I disagree because the provider is using CPT 2001… They are using a year that is not approved per the Texas Workers' Compensation Commission. This procedure is also global per the 1994 American Academy of Orthopaedic Surgeons – Global Service Data Handbook, pg. VII…Based on the re-review – (Carrier) does not believe (Requestor) is due any further reimbursement."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 07/12/01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $4407.50 for services rendered on the date of service in dispute above.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor $2000.00 for services rendered on the date of service in dispute above and denied any additional reimbursement as "F – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE OR USUAL AND CUSTOMARY VALUES AS ESTABLISHED BY (Audit Company)."; "F – THIS BILL HAS BEEN REVIEWED BY A REGISTERED NURSE."; "F – THIS MULTIPLE PROCEDURE WAS REDUCED 50% ACCORDING TO FEE SCHEDULE OR USUAL AND CUSTOMARY GUIDELINES."; "N – PROCEDURE NOT DOCUMENTED IN OPERATIVE REPORT." "4 – THIS PROCEDURE IS INCIDENTAL TO THE PRIMARY PROCEDURE, AND DOES NOT WARRANT SEPARATE REIMBURSEMENT."; "G – THIS PROCEDURE IS INCLUDED IN ANOTHER PROCEDURE PERFORMED ON THIS DATE." and "G – THIS PROCEDURE IS INCIDENTAL TO THE PRIMARY PROCEDURE THAT IS BILLED."

5. Per the Requestor's Table of Disputed Services, the amount in dispute is $2,407.50 for services rendered on the date of service in dispute above.

6. The Requestor has billed the Carrier using modifier –51. The MFG general instructions for this modifier states, "When multiple procedures are performed on the same day or at the same operative session, the major procedure or service is billed as listed. For the secondary additional, or lesser procedure(s) or service(s), add modifier '-51'. (Refer to Surgery Ground Rules.)

7. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
07/12/01	22899-51 22899-51 22899-51	$1200.00 $1200.00 $500.00	$1000.00 $1000.00 $0.00	F F N	DOP DOP DOP	MFG; General Instructions (III) (VI); SGR (I) (D); TWCC Rule 133.307 (g) (3) and (j); Texas Labor Code 413.011; 133.1 and 134.1; CPT Descriptor	The Requestor has billed an unlisted CPT code that, as such, is determined to be a DOP in accordance with the MFG. Per the MFG reimbursement requirements for DOP states, "An MAR is listed for each code excluding documentation of procedure (DOP) codes… HCPs shall bill their usual and customary charges. The insurance carrier will reimburse the lesser of the billed charge, or the MAR." CPT codes for which no reimbursement is listed (DOP) shall be reimbursed at the fair and reasonable rate." Medical documentation submitted indicates these charges are for the surgeon's services. The Medical Review Division has reviewed the file to determine which party has provided the most persuasive evidence. The provider has submitted additional reimbursement data: two example EOBs for charges billed for a similar procedure. The carrier asserts that they have paid a fair and reasonable reimbursement but have not submitted a methodology to support their reimbursement.. Per Rule 133.304 (i), "When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall: 1. develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement; 2. explain and document the method it used to calculate the rate of pay, and apply this method consistently; 3. reference its method in the claim file; and 4. explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement." The response from the carrier shall include, per Rule 133.307 (j) (1) (F), ".... if the dispute involves health care for which the Commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code 413.011 and §133.1 and 134.1 of this title;" . The law or rules are not specific in the amount of evidence that has to be submitted for a determination of fair and reasonable. In this case, the Requestor has provided some documentation to support their position that the amount billed is fair and reasonable. Additional reimbursement of **$900.00** is recommended.
07/12/01	64714	$657.50	$0.00	G	$1315.00	1994 Global Service Data for Orthopaedic Surgery (GSDOS); MFG; SGR (I) (D); CPT Descriptor	The Carrier has denied this service as "G – THIS PROCEDURE IS INCIDENTAL TO THE PRIMARY PROCEDURE THAT IS BILLED." The Requestor's primary procedure is CPT Code 63042. Pursuant to the GSDOS, this CPT code is global to the primary procedure billed. Therefore, **no** reimbursement is recommended.
07/12/01	27299-51	$850.00	$0.00	F,4	DOP	MFG; General Instructions (III) (VI); SGR (I) (D); CPT Descriptor	The Carrier has denied this service as "4 – THIS PROCEDURE IS INCIDENTAL TO THE PRIMARY PROCEDURE, AND DOES NOT WARRANT SEPARATE REIMBURSEMENT." and "F –. THIS MULTIPLE PROCEDURE WAS REDUCED 50% ACCORDING TO FEE SCHEDULE OR USUAL AND CUSTOMARY GUIDELINES"; The Requestor's primary procedure is CPT Code 63042. As DOP (no MAR listed), this CPT code cannot be denied as "global" to the primary procedure billed. Therefore the Carrier's denial code of "4" is inappropriate for this CPT code. In addressing Carrier's denial of "F", it is noted that the Carrier's 08/29/01 EOB shows a recommended reimbursement of $425.00 in accordance with the multiple procedure rule. Therefore, reimbursement of **$425.00** is recommended.
Totals		$4407.50	$2000.00				The Requestor **is** entitled to reimbursement in the amount of **$1325.00**.

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $1325.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 1st day of February 2003.

Denise Terry
Medical Dispute Resolution Officer
Medical Review Division
DT/dt