Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address:	MFDR Tracking #: M4-11-0091-01
LONESTAR ORTHOPEDICS 7007 NORTH FREEWAY, STE. 200 HOUSTON, TX 77076-1330	DWC Claim #:
	Injured Employee:
Respondent Name and Box #:	Date of Injury:
WAUSAU UNDERWRITERS INSURANCE Box #: 01	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "A bill was submitted for 05/5/2010 in the amount of $5,160.75 for a service provided to a covered, injured employee in accordance with TDIWC Rules. Procedure code 22851 was performed and submitted for reimbursement and denied as not reflected in the operative report. Procedure code was resubmitted for reconsideration with explanation that the Anulex Annular Mesh Patch as described in the operative report was used as the application of the prosthetic device. Procedure code 69990 was medically necessary to perform the procedure. As a result, the physician has the right to be reimbursed for such services provided as outlined in the Rules. This office took great lengths to ensure that the services were provided in accordance with the Rules and that the bill for the services was appropriately {sic}.

Amount in Dispute: $1349.92

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We base our payments on the Texas Fee Guidelines and the Texas Department of Insurance/Division of Workers' Compensation Commission's Acts and Rules. We have received the medical dispute filed by Lonestar Orthopedic for services rendered to Mr. Victor Escobar for the 05/05/2010 date of service. The bill and documentation attached to the medical dispute have been re-reviewed and our review is as follows: The disputed code CPT 22851, by AMA/CPT description is "Application of intervertebral biomechanicial device(s) (eg, synthetic cage(s), threaded bone dowel(s), methylmethacrylate) to vertebral defect or interspace", was denied as this charge was not reflected in the report as one of the procedures or services performed. The AMA/CPT has not as yet assigned a CPT code for repair of the annulus. The Centers for Medicare & Medicaid Services (CMS) has made public two new ICD-9-CM procedure codes for annular repair that will be published in the Federal Register. These new ICD-9-CM procedure codes will take effect October 1, 2008 and will include code 80.53 (repair of the annulus fibrosus with graft or prosthesis) and 80.54 (other and unspecified repair of the annulus fibrosus). According to Ingenix Encoder Pro, ICD-9 procedure code 80.53 crosswalks to CPT code 64999, unlisted procedure, nervous system. The operative report, pages 1 and 2, documents the procedure performed with these statements, "A longitudinal incision was made in the annulus and then we resected the nuclear material that was ready to come out." This statement documents the diskectomy which was reimbursed to Lonestar Orthopedic by CPT 63030. The repair of the incision into the annulus to perform the diskectomy is documented on pages 1 and 2 as "We then inserted the Anulex enclosed annular mesh patch into the nucleus, deployed it and pulled up on the mesh to place it against the annular wall. Two T sutures were ten {sic} placed on either side of the annular mesh and the stitch tightened. These statements describe the repair of an incision and per standards of medical/surgical care, repair of an incision is included in the surgical procedure performed. The repair of the annulus would therefore be incidental to the diskectomy, (paid by CPT 63030), should not be separately billed. These statements do not describe CPT 22851. It is also noted, the request to our utilization and management departments for preauthorization from Lonestar Orthopedic did not include a request for repair of the annulus, which is still considered an investigational procedure. Per TDI preauthorization guidelines, investigational procedures should be preauthorized. It is our assessment that , 1) CPT 22851 is the incorrect code to be billed for repair of the annulus, 2) repair of the incision to perform the diskectomy (CPT 63030) is incidental to the repair per standards of medical/surgical practice and 3) Lonestar Orthopedic did not request or received preauthorization for this investigational procedure. The 2nd disputed code CPT 69990,

microsurgical techniques, requiring use of operating microscope was denied as by clinical practice standards, this procedure is incidental to the related primary procedure billed. According to CMS Internet Only Manuals, Pub 100-4, Chapter 12, Section 20.4.5, Re: 69990 Operating Microscopes, effective January 1, 2000, the replacement code (CPT 69990) for modifier 20, microsurgical techniques requiring the use of operating microscopes may be paid separately only when submitted with certain CPT codes. CPT 63030 is not a listed code that allows the microscope to be paid separately. According to Encoder Pro/Medicare CCI edits, CPT 69990 is global/incidental to CPT 63030, should not be separately billed and the 59 modifier is not allowed. Liberty Mutual believes that Lonestar Orthopedic has been appropriately reimbursed for services rendered for the 05/05/2010 date of service."

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount D
5/5/10	22851	N/A	$881.01	$0.00
5/5/10	69990	N/A	$468.91	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

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

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §134.203 sets out the medical fee guidelines for professional services rendered on or after March 1, 2008.
3. 28 Tex. Admin. Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of health care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 6/3/10

   - X133 – This charge was not reflected in the report as one of the procedures or services performed.
   - U693 – By clinical practice standards, this procedure is incidental to the related primary procedure billed.
   - X394 – Our position remains the same if you disagree with our decision please contact the DWC Medical Dispute Resolution.
   - Claim has been re-evaluated based on additional documentation submitted; no additional payment due.

Issues

1. Does the submitted documentation support the service billed under CPT code 22851 and did the requestor seek pre-authorization for CPT code 22851?
2. Is CPT code 69990 considered bundled per the NCCI edits?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed CPT codes 63030 (lumbar laminotomy 1 interspace), 22851 (add on code –application of intervertebral biomechanical device) and 69990 (add on code – operating microscope). The carrier reimbursed the requestor for CPT code 63030 and this code is not in dispute. The description of CPT code 22851 is as follows: Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), threaded bone dowel(s), methylmethacrylate) to vertebral defect or interspace. The requestor's operative report submitted to support the charge, documents "We then inserted the Anulex enclosed annular mesh patch into the nucleus, deployed it and pulled up on the mesh to place it against the annular wall". A mesh patch is not included in the description of CPT code 22851. Pursuant to rule §134.203(a)(5) "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare. Further review of the information the requestor submitted in this dispute to support billing CPT code 22851, shows that there is no pre-authorization as required under rule §134.600. Pursuant to rule §134.600(p)(1) Non-emergency health care requiring preauthorization includes: inpatient hospital admissions, including the principal scheduled procedure(s). With the absence of documentation to support the billing of CPT code 22851 and the absence of pre-authorization for this code, reimbursement to the requestor for CPT code 22851 is not recommended.

2. The National Correct Coding Initiative (NCCI) edits support that CPT code 69990 (add on code) is a component procedure of CPT code 63030. Therefore, the Division concludes that reimbursement to the requestor for CPT code 69990 is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that reimbursement is due. As result, the amount ordered is $0.00.

PART VI: 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	Medical Fee Dispute Resolution Officer	12/15/10 Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (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. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

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