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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Bone & Joint Center

Respondent Name
Wausau Underwriters Insurance

MFDR Tracking Number
M4-15-0502-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
October 6, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Liberty Mutual denied CPT code 29125 documentation does not support level of service billed. The application of the arm splint is clearly documented in page two paragraph four of the operative report. Please review documentation and copy of a description of this code. We are requesting payment in full at this time due to the fact this was a clean claim."

Amount in Dispute: $2196.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill and documentation attached to the medical dispute have been re-reviewed and our position remains unchanged. Our rationale is as follows:

64727-59-LT: Internal neurolysis, requiring use of operating microscope. Denied as This charge was not reflected in the report as one of the procedures/services performed. (X133). First, no use of microscope being utilized in operative report. CPT description includes 'requiring use of microscope.' Secondly, no mention of 'neurolysis' in body of OP report.

29125-59-LT: Denied as Documentation does not support level of service billed. (X901). 29125 has CCI with 64721: Standards of medical/surgical practice. Modifier 59 not supported as same body part. CMS developed the National Correct Coding Initiative (also referred to as CCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. CCI edits are pairs of CPT or HCPCS Level II codes that are not separately payable under certain circumstances. The edits are applied to services billed by the same provider for the same beneficiary on the same date of service. All claims are processed against CCI tables. -59 Distinct Procedural Service: 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 or 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 or excision
- separate lesion
- separate injury (or area of injury in extensive injuries)

not normally encountered 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. [1]

Modifier 59 is to be appended to a code when the code meets the above referenced criteria. Regarding this bill and date of service, the appending of the modifier 59 is not supported."

Response Submitted by: Liberty Mutual, PO Box 7071, London, KY 40742

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 24, 2014	Internal neurolysis (64727-59-LT) & Application of short splint (29125-59-LT)	$2196.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 fee guidelines for professional services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   For CPT Code 64727-59-LT
   - B12 – Services not documented in patients' medical records.
   - X133 – This charge was not reflected in the report as one of the procedures or services performed.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - U301 – This item has been reviewed on a previously submitted bill, or is currently in process. Notification of decision has been previously provided or will be issued upon completion of our review.

   For CPT Code 29125-59-LT
   - 150 – Payer deems the information submitted does not support this level of service.
   - X901 – Documentation does not support level of service billed.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - U301 – This item has been reviewed on a previously submitted bill, or is currently in process. Notification of decision has been previously provided or will be issued upon completion of our review.

Issues

1. Does the documentation support CPT Code 64727-59-LT?
2. Does the documentation support CPT Code 29125-59-LT?
3. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.203 (b) 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."

   CPT Code 64727 is defined as "Internal neurolysis, requiring use of operating microscope." Internal neurolysis is further defined by the following: "The outer sheath of the affected nerve is opened with a microscope. Scar tissue within the nerve may also be removed" (NYU Langone Medical Center, Neurosurgery Dept.). The submitted documentation does not support that this procedure was performed.
2. CPT Code 29125 is defined as "Application of short arm splint (forearm to hand); static." Further, "According to CPT guidelines, cast application or strapping (including removal) is **only reported as a replacement procedure or when the cast application or strapping is an initial service performed without a restorative treatment or procedure**" [emphasis added]. This code specifically excludes "restorative procedures that included application and removal of the initial splint or strap." This code was billed in conjunction with CPT Code 64721.

By adding the additional modifier 59, the requestor is indicating that the application of the short arm splint is "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." While the application of a short arm splint is documented, the submitted documentation does not support the level of service required by the modifier 59.

3. Because the services in question are not supported by documented evidence, no further reimbursement is recommended.

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

		January 30, 2015
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 in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

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