Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

JORDAN J. JUDE, MD

Respondent Name

MITSUI SUMITOMO INSURANCE USA

MFDR Tracking Number

M4-18-4343-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

JULY 17, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT codes 63047-59, 38220-59, and 61783 were performed by the surgeon and represent surgical work that was approved by the carrier, was medically necessary, and is documented as performed in the operative report. These procedures have been denied by the carrier in error as bundled to other procedures. Modifier 59 has been appended to 63047 as it was performed separately for work not described in the bundled CPT code 22633. The provider documents decompression of the neural elements; the CPT description of 22633 excludes decompression. Modifier 59 is appropriate as this is performed at a separate site; this was a spine surgery and 38220 was performed at the iliac crest. 61783 is appropriately reported as a separate and although a 59 modifier is not appropriate, the imaging guidance is separately reportable per CPT and ought to be reimbursed separately ."

Amount in Dispute: $7,300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider was reimbursed $8,099.29. The provider is not entitled to any additional reimbursement.."

Response Submitted by: Flahive, Ogden & Latson.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 29, 2017	CPT Code 63047-59 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar	$5,000.00	$0.00
	CPT Code 38220-59 Diagnostic bone marrow; aspiration(s)	$500.00	$0.00
	CPT Code 61783 Stereotactic computer-assisted (navigational) procedure; spinal (List separately in addition to code for primary procedure)	$1,800.00	$0.00
TOTAL		$7,300.00	$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 the reimbursement guidelines for professional service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 59-Distinct Procedural Service.
   - 236-This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on this same day according to the National Correct Coding Initiative or workers compensation state regulations/fee schedule requirements.
   - R89-CCI: Misuse of column 2 code with column 1 code.
   - W3-Appeal/reconsideration.

Issues

1. What is the applicable fee guideline for professional services?
2. Is the allowance of CPT code 63047-59 included in the allowance of another service/procedure rendered on the disputed date? Is the requestor entitled to reimbursement?
3. Is the allowance of CPT code 38220-59 included in the allowance of another service/procedure rendered on the disputed date? Is the requestor entitled to reimbursement?
4. Is the allowance of CPT code 61783 included in the allowance of another service/procedure rendered on the disputed date? Is the requestor entitled to reimbursement?

Findings

1. The fee guidelines for disputed services are found in 28 Texas Administrative Code §134.203.
2. The requestor billed $5,000.00 and was paid $0.00 for code 63047-59 based upon "236-This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on this same day according to the National Correct Coding Initiative or workers compensation state regulations/fee schedule requirements."

   28 Texas Administrative Code §134.203(a)(5) states, "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."

   On the disputed date of service the requestor billed CPT codes 22830, 63047-59, 22633, 22614, 22842, 22853, 20936, 20930, 38220-59, and 61783.

   28 Texas Administrative Code §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."

   Per CCI edits, CPT code 63047 is a component of code 22633; however, a modifier is allowed to differentiate the service.

   The requestor appended modifier 59-Distinct Procedural Service" to code 63047 to differentiate it from 22633. Modifier "59" is defined as "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."

The requestor wrote on the Operative Report under the heading "Surgical Procedure(s) Performed: 4.CPT code 22633: L2-L3 lumbar interbody and posterolateral arthrodesis." The requestor did not list the procedure for code 63047. The requestor noted in the report that "left L2-L3 hemilaminectomies ..included a proximal foraminotomy…discectomy." The division finds the requestor did not support the use of modifier 59, specifically a "different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury." Therefore, the respondent's denial of payment is supported.

3. Per the submitted medical bill the requestor billed $500.00 and was paid $0.00 for code 38220-59 based upon "236-This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on this same day according to the National Correct Coding Initiative or workers compensation state regulations/fee schedule requirements."

   Per CCI edits, CPT code 38220 is a component of codes 22633, 22842, 22614, 22853, 22830; a modifier is not allowed to differentiate the service. Therefore, the respondent's denial of payment is supported.

4. The requestor billed $1,800.00 and was paid $0.00 for code 61783 based upon "236-This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on this same day according to the National Correct Coding Initiative or workers compensation state regulations/fee schedule requirements."

   Per CCI edits, code 61783 has a conflict with code 63047; however, a modifier is allowed to differentiate the service and override conflict. The requestor did not append a modifier to this code. Therefore, the respondent's denial of payment is supported.

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

		08/22/2018
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.