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
DAVID M. BLOOME, MD

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number
M4-18-4427-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
JULY 20, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have added a 59 modifier to code 29876."

Amount in Dispute: $1,403.60

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."

Response Submitted by: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 2, 2017	CPT Code 29876-59-LT Knee Arthroscopy	$1,403.60	$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, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - X212-This procedure is included in another procedure performed on this date.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - W3-Request for reconsideration.
   - MX60-Per NCCI, the procedure code is denied, based on standard of medical, surgical practice, procedure included in 29880.

Issues

1. What is the applicable fee guideline for professional services?
2. Is the allowance of CPT code 29876-59-LT included in the allowance of code 29880-LT? Is the requestor entitled to reimbursement?

Findings

1. The fee guidelines for disputed services are found in 28 Texas Administrative Code §134.203.
2. Based upon the submitted documentation the requestor billed $2,960.00 and was paid $0.00 for code 29876-59-LT based upon "MX60-Per NCCI, the procedure code is denied, based on standard of medical, surgical practice, procedure included in 29880."

   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 29880-LT and 29876-59-LT.

   - CPT code 29880 is defined as "Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed."
   - CPT code 29876 is defined as "Arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments (eg, medial or lateral)."

   The requestor appended modifiers "LT-left side" and "59-Distinct Procedural Service to code 29876.

   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 29876 is a component of code 29880; however, a modifier is allowed to differentiate the service.

   The requestor appended modifier 59-Distinct Procedural Service" to code 29876 to differentiate it from 29880. 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."

   Per CPT code manual, knee arthroscopies are found at codes 29866 through 29887.

   Per National Correct Coding Initiative Policy Manual For Medicare Services, Chapter IV, Section (E)(8), effective January 1, 2017, "Arthroscopic synovectomy of the knee may be reported with CPT codes 29875 (limited synovectomy, "separate procedure") or 29876 (major synovectomy of two or three compartments). A synovectomy to "clean up" a joint on which another more extensive procedure is performed is not separately reportable. CPT code 29875 should never be reported with another arthroscopic knee procedure on the ipsilateral knee. CPT code 29876 may be reported for a medically reasonable and necessary synovectomy with another arthroscopic knee procedure on the ipsilateral knee if the synovectomy is performed in two compartments on which another arthroscopic procedure is not performed. For example, CPT code 29876 should never be reported for a major synovectomy with CPT code 29880 (knee arthroscopy, medial AND lateral meniscectomy) on the ipsilateral knee since knee arthroscopic procedures other than synovectomy are performed in two of the three knee compartments."

   The requestor wrote in the Operative Report: "OPERATIONS PERFORMED: 1.Left knee arthroscopic partial medial meniscectomy. 2. Left knee arthroscopic partial lateral meniscectomy. 3. Left knee arthroscopic partial

synovectomy in multiple compartments. 4. Left knee arthroscopic chondroplasty of medial femoral condyle and trochlear chondral injuries."

The requestor wrote in the operative report to support billing code 29880 "partial medial and lateral meniscectomies were performed… We then utilized the shaver to remove unstable cartilage at the medial femoral condyle and throchlea." To support billing code 29876 the requestor wrote, "…partial synovectomy involving the notch and patellofemoral region."

Per NCCI Policy Manual, Chapter IV, Section (E)(8), code 29876 may not be billed with code 29880 when performed on the same knee. Based upon the operative report the procedures were performed on the left knee. The division finds the respondent's denial of payment for code 29876-59-LT is supported. As a result, reimbursement is not 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

Signature	Medical Fee Dispute Resolution Officer	08/20/2018 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.