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
WAYNE O. ALANI, MD

Respondent Name
TRAVELERS INDEMNITY CO

MFDR Tracking Number
M4-19-1431-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
NOVEMBER 13, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the American Academy of Orthopedic Surgeons (AAOS) complete Global Service Data for Orthopedic Surgery, Code 29875 is not included in the global package for 29880 when performed in a separate compartment. Code 29880 was performed in the medial and lateral compartments, whereas code 29875/59/RT was done in the patella compartment."

Amount in Dispute: $1,057.94

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider contends they are entitled to separate reimbursement for CPT code 29875-59 (limited synovectomy). The Carrier has reviewed the documentation and determined the Provider was properly reimbursed. The Medicare edits reflect that CPT code 29875 is included in the reimbursement for the primary procedure of CPT code 29880 (medial and lateral meniscectomy). Although the Provider alleges the addition of the -59 modifier allows for separate reimbursement, as the synovectomy was performed in the patellar compartment while the meniscectomy was performed in the medial and lateral compartments. There is no such anatomical space as the patellar compartment. The patella is a bone which sits in front of the femur across the lateral compartment. As documented by the operative report included with the DWC-60, the lateral compartment meniscectomy was performed and billed under CPT code 29880. As such, reimbursement for 29875 was included in the reimbursement for 29880 per the Medicare edits. The Provider is not entitled to separate reimbursement for the disputed services."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 11, 2018	CPT Code 29875-59-RT	$1,057.94	$0.00

FINDINGS AND DECISION

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

Background

1. 28 Texas Administrative Code §133.307, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, 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:
   - 97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 4063-Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting.
   - 86-Service performed was distinct or independent from other services performed on the same day.
   - 90-Allowance for this procedure was calculated by subtracting the base code value from the non-base code value (when procedures are within the same family).
   - 243-The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.

Issues

Is the value of CPT code 29875 included in the value of code 29880 billed on the disputed date? Does the documentation support a separate service? Is the requestor entitled to reimbursement?

Findings

28 Texas Administrative Code §134.203(b)(1) "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: 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."

According to the explanation of benefits, the respondent denied reimbursement for code 29875-59-RT based upon reason codes "97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated," and "243-The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed."

On the disputed date of service, the requestor billed CPT codes 29880-RT and 29875-59-RT.

Per CCI edits, CPT code 29875 is a component of CPT code 29880; however, a modifier is allowed to differentiate the service. A review of the requestor's billing finds that the requestor appended modifier "59-Distinct Procedural Service" to CPT code 29875.

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 respondent maintains the denial of payment for code 29875 based upon "The Medicare edits reflect that CPT code 29875 is included in the reimbursement for the primary procedure of CPT code 29880 (medial and

lateral meniscectomy). Although the Provider alleges the addition of the -59 modifier allows for separate reimbursement, as the synovectomy was performed in the patellar compartment while the meniscectomy was performed in the medial and lateral compartments. There is no such anatomical space as the patellar compartment."

The requestor wrote, "Code 29880 was performed in the medial and lateral compartments, whereas code 29875/59/RT was done in the patella compartment."

The National Correct Coding Initiative Policy Manual for Medicare Services Chapter 1, (J), effective January 1, 2018, defines "separate procedure" as "The narrative for many HCPCS/CPT codes includes a parenthetical statement that the procedure represents a "separate procedure". The inclusion of this statement indicates that the procedure can be performed separately but should not be reported when a related service is performed. A "separate procedure" should not be reported when performed along with another procedure in an anatomically related region through the same skin incision or orifice, or surgical approach.

A CPT code with the "separate procedure" designation may be reported with another procedure if it is performed at a separate patient encounter on the same date of service or at the same patient encounter in an anatomically unrelated area often through a separate skin incision, orifice, or surgical approach. Modifier 59 or a more specific modifier (e.g., anatomic modifier) may be appended to the "separate procedure" CPT code to indicate that it qualifies as a separately reportable service."

The National Correct Coding Initiative Policy Manual for Medicare Services Chapter 4, (E)(8), effective January 1, 2018, states " 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 *shall not* 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 *shall not* 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 Division finds per NCCI Policy Manual for Medicare Services, Chapter 4(E)(8), "CPT code 29875 *shall not* be reported with another arthroscopic knee procedure on the ipsilateral knee." Both procedures, CPT codes 29880 and 29875, were performed on the right knee; 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

Signature	Medical Fee Dispute Resolution Officer	01/17/2019 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, 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 MFDR 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.