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 BACK INSTITUTE

Respondent Name
ACE AMERICAN INSURANCE CO

MFDR Tracking Number
M4-19-4450-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
JUNE 10, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We billed procedure code 22899 for additional work performed with the Anterior Lumbar Interbody Fusion, 22558. The claim continues to deny this code as the value of the procedure is bundled within the value of another procedure billed. By definition, the ALIF includes a minimal discectomy. We are doing much more than a minimal discectomy. We are removing the disc back to the posterior longitudinal ligament and decompressing lateral recess bilateral. Endplate preparation is also performed with full removal of cartilage on both vertebrae. The additional work…warrants additional reimbursement."

Amount in Dispute: $7,812.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT 22899 59 was billed for Extensive discectomy work with anterior lumbar interbody fusion. This was denied as not supported/included under the payment allowance of 22558 and 22585."

Response Submitted by: Helmsman Management Services LLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 1, 2019	CPT Code 22899-59	$7,812.16	$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 the disputed service.
3. 28 Texas Administrative Code §134.1, provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

- 16, 5832-Documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge.
- 97, 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.
- W3-Additional payment made on appeal/reconsideration

Issues

Is the requestor entitled to reimbursement for CPT code 22899-59 rendered on March 1, 2019?

Findings

1. The fee guidelines for disputed services are found in 28 Texas Administrative Code §134.203.
2. 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."

   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."

   On the disputed date of service, the requestor billed CPT codes: 22899-59, 22558-62-22, 22585-62-22, 22853, 22853-59 for the surgeon's services.

   These codes are described as:

   - 22899- Unlisted procedure, spine.
   - 22558- Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar.
   - 22853- Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure).
   - 22585-Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure).

   The requestor appended modifiers:

   - "59-Distinct Procedural Service" to code 22899 to differentiate it from 22558. 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."

   According to the explanation of benefits, the respondent denied reimbursement for CPT code 22899-59 based upon reason codes "16, 5832-Documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge," and "97, 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."

   A review of the submitted Operative Report from Dr. Renato V. Bosita, supports CPT code 22899, "…a complete radical discectomy to the level of the posterior longitudinal ligament. I completely removed the disk."

   To determine reimbursement for code 22899 the division refers to 28 Texas Administrative Code §134.203(f).

28 Texas Administrative Code §134.203(f) states, “For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).”

CPT code 22899 does not have a relative value unit assigned to it; therefore, reimbursement shall be provided in accordance with 28 Texas Administrative Code §134.1.

28 Texas Administrative Code §134.1(e)(3) states, “ in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section.”

28 Texas Administrative Code §134.1(f)(1-3) states, “Fair and reasonable reimbursement shall:

(1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.”

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(O) requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable.” Review of the submitted documentation finds that:

- The requestor asks to be reimbursed the full amount of the billed charges in support of which the requestor states “We billed procedure code 22899 for additional work performed on with the Anterior Lumbar Interbody Fusion, 22558.”
- The requestor does not discuss or explain how reimbursement $7,812.16 for code 22899-59 is a fair and reasonable reimbursement.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute.

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

		07/11/2019
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.