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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ORTHOTEXAS PHYSICIANS AND SURGEONS

Respondent Name
OLD REPUBLIC INSURANCE CO

MFDR Tracking Number
M4-19-4894-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
JULY 16, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On this date of service, CPT 22845 denied stating 'services not furnished directly to the patient or not documented'. I have highlighted & circled the op report that supports CPT 22845."

Amount in Dispute: $3,640.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "it is the carrier's position that the total amount paid was $6,943.46…CPT code 22845 is not supported by documentation."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 26, 2018	CPT Code 22558	$0.00	$0.00
	CPT Code 22612	$0.00	$0.00
	CPT Code 22840	$0.00	$0.00
	CPT Code 22845	$3,640.00	$0.00
	CPT Code 22853	$0.00	$0.00
Total		$3,640.00	$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 code:
    - 00403, 112-Service not furnished directly to the patient and/or not documented.
    - 663-Reimbursement has been calculated according to state fee schedule guidelines.
    - P12-Workers' compensation jurisdictional fee schedule adjustment.
    - W3-Additional payment made on appeal/reconsideration.
    - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly the first time.

Issues

Does the documentation support billing CPT code 22845? Is the requestor entitled to reimbursement?

Findings

1. The fee guidelines for disputed service is found in 28 Texas Administrative Code §134.203.
2. The respondent denied reimbursement for code 22845 based upon a lack of documentation to support the billed service.
3. 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."
4. 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…"

   On the disputed date of service, the requestor billed codes 22558-62, 22612-51, 22840, 22845-XU, and 22853.

   Per CCI edits, CPT code 22845 is a component of code 22853; however, a modifier is allowed to differentiate the service.

   CPT code 22845 is described as "Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)." The requestor appended modifier "XU-Unusual Non-Overlapping Service: The use of a service that is distinct because it does not overlap usual components of the main service" to code 22845.

   CPT code 22853 is described as "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)."
5. A review of the Operative report finds:
    - "Anterior lumbar interbody fusion at L5-S1 with insertion of PEEK interbody device."
    - "Posterior instrumented spinal fusion at L5-S1 with bilateral pedicle screw instrumentation."
    - "Anterior spinal instrumentation/fixation…L5 and S1."
6. The requestor wrote, "I have highlighted & circled the op report that supports CPT 22845." Based upon the submitted report, the highlighted and circled section of the op report refers to "Posterior instrumented spinal fusion." This procedure does not support code 22845 that is used for "Anterior instrumentation".

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that 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

		08/22/2019
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, 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.