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
JOHN A. SAZY, MD

Respondent Name
ASSOCIATED INDEMNITY CORP

MFDR Tracking Number
M4-20-2331-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
MAY 20, 2020

REQUESTOR'S POSITION SUMMARY

"The primary procedure code: posterior spinal fusion CPT 22612 along with the additional codes CPT 22614 X2 have not been paid. This is the main procedure code and is always paid and is not Global to any other codes. Also not paid is 22630-59 and 22632, codes for the T-LIF."

Amount in Dispute: $6,570.44

RESPONDENT'S POSITION SUMMARY

"The carrier's EOB dated January 8, 2020 recommended reimbursement of $3,385.67. The provider was not reimbursed for CPT codes 22612, 22614, 22630-59 and 22632. The carrier's position concerning reimbursement is identified on its EOBs. It is the carrier's position that no additional reimbursement is required pursuant to the Medical Fee Guidelines."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 18, 2019	CPT Code 22612	$2,966.95	$2,966.95
	CPT Code 22614 (X2)	$1,462.42	$1,462.42
	CPT Code 22630-59	$1,465.35	$0.00
	CPT Code 22632	$675.72	$0.00
TOTAL		$6,570.44	$4,429.37

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 (DWC).

Background

1. 28 Texas Administrative Code §133.307, effective May 31, 2012 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 17-Requested information was not provided or was insufficient/incomplete. Additional information is supplies using the remittance advice remark codes whenever appropriate.
   - X17-Requested information was not provided or was insufficient/incomplete.
   - P12-Workers' compensation state fee schedule adjustment.
   - 790-The charge was reimbursed in accordance to the Texas Medical Fee Guideline.
   - 95-Plan procedure not followed.
   - U03-The billed service was reviewed by UR and authorized.
   - FZ8-Complex bill review denial.
   - 59-Processed based on multiple or concurrent procedure rules.
   - 350-Bill has been identified as a request for reconsideration or appeal.
   - W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - 375-Codes 22612, 22614, 22630 and 22632 are denied. The main reason for denial is according to the 2019 CPT manual on page 136-137 it specifically states "Do not report 22630 in conjunction with 22612 for the same interspace and segment, use 22633." Likewise 22614 and 22632 would be denied and according to CPT the correct code should be 22634. In addition there are NCCI edits for the codes and the surgery is done at the same L4-5 and L5-S1 interspaces therefore modifiers would be inappropriate. It is important that the provider understand the reason for denial.
   - 18-Exact duplicate claim/service.
   - 224-Duplicate charge.

Issues

Is the requestor entitled to additional reimbursement for CPT codes 22612, 22614 X2, 22630-59, and 22632?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $6,570.44 for CPT codes 22612, 22614 X2, 22630-59, and 22632 rendered on September 18, 2019.
2. The fee guidelines for disputed services is found at 28 TAC §134.203.
3. 28 TAC §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 TAC §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."
5. On the disputed date of service, the requestor billed the following: 22612, 22614 (X2), 22630-59, 22632, 22842, 22853, 22899-59, 64722-22 and 20937. The respondent paid 22842, 22853, 22899-59 and 20937.

   The codes are described as:

   - 22612- Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed).
   - 22614- Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure).
   - 22630- Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar.

- 22632- Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure).

- 22842- Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure).

- 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).

- 22899- Unlisted procedure, spine.

- 64722- Decompression; unspecified nerve(s) (specify).

- 20937- Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (List separately in addition to code for primary procedure).

6. CPT Code 22630-59 and 22632

   The respondent denied reimbursement for these codes based upon reason code “375” and “P12.”

   Per CCI edits, CPT code 22630 is mutually exclusive to code 22612 and a modifier is not applicable. Because, CPT code 22632 is the add-on code for 22630 the policy applies. Based upon CCI edits reimbursement is not recommended.

7. CPT code 22612 and 22614

   The respondent denied reimbursement based upon “375-Codes 22612, 22614, 22630 and 22632 are denied. The main reason for denial is according to the 2019 CPT manual on page 136-137 it specifically states ‘Do not report 22630 in conjunction with 22612 for the same interspace and segment, use 22633.’ Likewise 22614 and 22632 would be denied and according to CPT the correct code should be 22634. In addition there are NCCI edits for the codes and the surgery is done at the same L4-5 and L5-S1 interspaces therefore modifiers would be inappropriate. It is important that the provider understand the reason for denial.”

   The National Correct Coding Initiative Policy Manual for Medicare Services, Chapter IV, Section(F)(5), effective January 1,2019 states:

   > CPT codes 22600-22614 describe arthrodesis by posterior or posterolateral technique. CPT codes 22630-22632 describe arthrodesis by posterior interbody technique. CPT codes 22633-22634 describe arthrodesis by combined posterior or posterolateral technique with posterior interbody technique. These codes are reported per level or interspace. CPT code 22614 is an add-on code that may be reported with primary CPT codes 22600, 22610, 22612, 22630, or 22633. CPT code 22632 is an add-on code that may be reported with primary CPT codes 22612, 22630, or 22633. CPT code 22634 is an add-on code that may be reported with primary CPT code 22633.
   >
   > If a physician performs arthrodesis across multiple interspaces using the same technique in the same spinal region, the physician shall report a primary code for the first interspace and an add-on code for each additional interspace. If the interspaces span two different spinal regions through the same skin incision, the physician shall report a primary code for the first interspace and an add-on code for each additional interspace. If the interspaces span two different spinal regions through different skin incisions, the physician may report a primary code for the first interspace through each skin incision and an add-on code for each additional interspace through the same skin incision.
   >
   > If a physician performs arthrodesis across multiple contiguous interspaces through the same skin incision using different techniques, the physician shall report one primary code for the first interspace and add-on codes for each additional interspace.
   >
   > If a physician performs arthrodesis across multiple non-contiguous interspaces through the same skin incision using different techniques, the physician shall report one primary code for the first interspace and add-on codes for each additional interspace.
   >
   > If a physician performs arthrodesis across multiple non-contiguous interspaces through different skin incisions using different techniques, the physician may report one primary code for the first

interspace through each skin incision and add-on codes for each additional interspace through the same skin incision.

The Operative Report indicates the claimant underwent the following procedures:

The Operative Report indicates the procedures were performed

Based upon NCCI Policy Manual and Operative Report, the requestor billed for the ...correctly; therefore, reimbursement is recommended.

8. Per 28 Texas Administrative Code §134.203(c)(1)(2), “To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.
(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the DWC had been using this MEI annual percentage adjustment: The 2006 DWC conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) DWC conversion factor in 2007.”

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

   The 2019 DWC Conversion Factor is 74.29

   The 2019 Medicare Conversion Factor is 36.0391

   Per the CMs 1500, the services were rendered in Hurst, TX; therefore, the Medicare locality is “Fort Worth, Texas”.

   The following table includes all of the services rendered on the disputed date of service to ensure reimbursement for the disputed codes is per the fee guideline. Using the above formula, the DWC finds the MAR is:

Code	Medicare Participating Amount	MPR of 50% Applies	MAR	Insurance Carrier Paid	Amount Due
22612	$1,599.23	N	$3,296.61 or less	$0.00	$2,966.95
22614 (X2)	$394.13	N	$1,624.90 or less	$0.00	$1,462.42
22842	$770.25	N	$1,587.77	$1,587.77	Not in dispute
22853 (X2)	$260.56	N	$1,074.22	$1,074.22	Not in dispute
64722	$360.38	Y	$371.44	$0.00	Not in dispute
22899	Fair & Reasonable	N	Fair & Reasonable	$375.00	Not in dispute
20937	$175.87	N	$362.53	$348.68	Not in dispute
Total Due					$4,429.37

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $4,429.37.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $4,429.37 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		6/18/2020
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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **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.