TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
John Anthony Sazy

Respondent Name
Old Republic Insurance Co

MFDR Tracking Number
M4-23-1943-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
April 5, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 13, 2022	22614/1 unit	$700.45	$0.00
May 13, 2022	22630-59	$1421.52	$0.00
	Total	$2121.97	$0.00

Requestor's Position

"CPT code 22614: this is for the additional level that was not paid. "A vertebral segment describes the basic constituent into which the spine may be divided. It represents a single vertebral bone with it associated articular processes and laminae." The posterior fusion done was for L2 to L3 which is 2 vertebral segments and only one was paid (22612). So the second vertebral segment has to be paid.

Amount in Dispute: $2121.97

Respondent's Position

"Rule §134.20d(a)(5) indicates the Medical Fee Guidelines for Texas includes "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values including its coding… CPT code 22614 is per interspace, not vertebral bone/level. The most recent description (2022) is… "Arthrodesis, posterior or posterolateral technique, single interspace: each additional interspace (list separately in addition to code for primary procedure.)

There was only one interspace fused, L2-L3. The Requestor indicates one interspace fusion occurred in their OP report. …As the interspace was covered under 22612, no additional payment is recommended for 22614. The surgeon did perform an interbody fusion: …22630 is included to 22612 billed on line 1 of this particular bill and not separately reimbursable when performed on the same interspace. While CCI edits do indicate a modifier may be used to override the edits, the override must be fully supported by documentation. Documentation indicates 22630 was performed in the sane interspace, thus no separate payment allowed."

Response submitted by: CorVel

Findings and Decision

Authority

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

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.203 sets out the billing and coding guidelines of professional medical services.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 59 – Allowance based on Multiple Surgery Guidelines
- RO9 – CCI: CPT Manual and CMS coding manual instructions
- RD8 – Multiple Procedure/2nd Procedure (50%)
- 59 – Distinct Procedural Service
- P12 – Workers' Compensation State Fee Schedule Adj
- RD7 – Multiple Procedure/1st Procedure
- B12 – Svcs not documented in patient medical record
- B13 – Payment for service may have been previously paid

Issues

1. Is the requestor's position statement supported?

2. Is the insurance carrier's denial supported?

Findings

1. The requestor states, "CPT Code 22614: this is for the additional level that was not paid. …The posterior fusion done was for L2 to L3 which is 2 vertebral segments and only one was paid. So the second vertebral segment has to be paid."

   The submitted code in dispute is 22614 – Arthrodesis, posterior or posterolateral technique, single interspace; each additional interspace (List separately in addition to code for primary procedure).

   The requestor's position regarding second vertebral segment is not supported and will not be considered in this review.

2. DWC Rule 134.203 (b) 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.

   Review of the submitted medical bill found the requestor's medical bill contained,

   - Code 22612 - Arthrodesis, posterior or posterolateral technique, single interspace; lumbar (with lateral transverse technique, when performed) NOT IN DISPUTE and an add on code.
   - Code 22614 – Arthrodesis, posterior or posterolateral technique, single interspace; each additional interspace.

   The insurance carrier denied Code 22614 as Services not documented in patient medical records and a note that states, "Documentation does not support Arthrodesis, posterior or posterolateral technique of ADDITIONAL interspace was…"

   Review of the submitted "Operative Report" list procedures performed as:

   1. Right iliac crest bone graft, fat graft, allograft
   2. L2-3 laminectomy
   3. Facet osteotomy L2-3
   4. Transforaminal lateral interbody fusion L2-3
   5. Posterior spinal fusion L2 to L3
   6. Neuromonitoring

   The CPT definition of a vertebral interspace is the non-body compartment between two adjacent vertebral bodies, which contains the intervertebral disk, and includes the nucleus pulposus, annulus fibrosus, and two cartilaginous endplates.

   The submitted operative report indicates only procedures "L2-L3" or one interspace. The insurance carrier's denial is supported. No additional payment is recommended.

   Regarding 22630 -59, - Arthrodesis, posterior interbody technique including laminectomy

and/or discectomy to prepare interspace (other than for decompression), single interspace, lumbar. The 59 modifier is defined as "Distinct Procedural Service." 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 injures) not ordinarily encountered or performed on the same date by the same individual.

The submitted operative report states, "The patient then had inferior laminectomy of L2 and superior laminectomy of L3 performed, decompressing the spine at that segment."

The operative report indicates the arthrodesis was for decompression and does not support a different session.

The insurance carrier's denial is supported. No additional payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 15, 2023 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other

parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.