

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on June 07, 2004.

## I. DISPUTE

Whether there should be reimbursement for CPT codes 29822 for date of service January 9, 2004. Although this dispute was docketed as a medical necessity dispute, the insurance carrier representative has documented on the TWCC-60 response that “This code 29822 was denied per system edit as included in CPT 29827”. The payment exception code used by the insurance carrier was “U693 – By clinical practice standards, this procedure is incidental to the related primary procedure billed”. Therefore, the dispute will be reviewed per the Texas Fee Schedule and Medicare Fee Schedule.

## II. RATIONALE

The Requestor states in their rationale on the Table of Disputed Services that... “The insurance denied this procedure as being bundled with another procedure performed at the same time. Per CCI edits and Global Service Data for Orthopaedic Surgery this procedure should not be considered in with any of the procedure that were performed on this date.”

The Respondent stated in their response on the Table of Disputed Services that... “This code 29822 was denied per system edit as included in CPT 29827”.

- CPT Code 29822-59 for date of service 01/09/04 denied as “U693 – By clinical practice standards, this procedure is incidental to the related primary procedure billed”. According to the Medicare Correct Coding Initiative the dispute service is global to the primary procedure code. The health care provider attached modifier –59 which defines the CPT code used as a distinct procedural service. According to the AMA CPT 2004 Standard Edition, the description of modifier –59 is “For procedure(s)/service(s) not ordinarily performed or encountered on the same day by the same physician, but appropriate under certain circumstances (eg. Different site or organ system, separate excision or lesion), use the ‘-59’ modifier”. The submitted operative report does not meet the criteria for modifier –59; reimbursement is not recommended.

### **III. DECISION**

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor is not entitled to reimbursement for CPT code 29822.

The above Findings and Decision is hereby issued this 30<sup>th</sup> day of July 2004.

Marguerite Foster  
Medical Dispute Resolution Officer  
Medical Review Division

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