SOAH DOCKET NO. 454-14-0405.M4-NP
DWC NO. _____

TEXAS MUTUAL INSURANCE COMPANY,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
v.	§	**OF**
	§	
DOCTORS HOSPITAL AT RENAISSANCE,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Texas Mutual Insurance Company (Carrier) challenges the order granting additional reimbursement to Doctors Hospital at Renaissance (Provider) for services provided to an injured worker. The issue in this case is whether Provider is entitled to reimbursement for services billed under Current Procedural Terminology code (CPT) 29879. Carrier contends, based on applicable fee guidelines, that Provider is not entitled to reimbursement for services billed under CPT 29879, if CPTs 29879 and 29881 were performed during the same surgical procedure. The Administrative Law Judge (ALJ) concludes that Provider is entitled to an additional $1,799.65 as reimbursement for services rendered under CPT 29879.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

There are no issues of notice or jurisdiction in this proceeding. Therefore, these matters are addressed in the Findings of Fact and Conclusions of Law without further discussion here.

Provider filed a request for medical fee dispute resolution with the Texas Department of Insurance, Division of Workers' Compensation (Division). On July 16, 2013, the Division issued its Medical Fee Dispute Resolution Decision (MFDR Decision). On September 27, 2013, Carrier requested a hearing at the State Office of Administrative Hearings (SOAH) to contest the Division's determination. On October 1, 2013, the Division issued a Notice of Hearing. A hearing convened before ALJ Steven M. Rivas on November 1, 2013, at SOAH's facilities in

Austin, Texas. Carrier was represented by Bryan W. Jones, attorney. Provider's Insurance Collections Manager, Idalia Rodriguez, appeared on Provider's behalf. Evidence was received and the record closed on the same day.

II. DISCUSSION

A. Applicable Law

As stated in the MFDR Decision, the Texas Department of Insurance rule at 28 Texas Administrative Code § 134.403 (the rule) applies to medical services provided in an outpatient acute care hospital on or after March 1, 2008. Claimant's treatment was provided in an outpatient hospital setting on May 24, 2012. Therefore, the rule applies to this case. To calculate maximum allowable reimbursement, the rule requires use of the Medicare facility-specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register* together, with the application of minimal modifications as set forth in the rule.

B. Relevant Facts

Claimant sustained a compensable knee injury on ____, and underwent knee surgery at Provider's facility in Edinburg, Texas, on ___. Provider sent a $37,868.63 bill to Carrier for its services, which contained several CPT codes identifying services rendered to Claimant. Carrier reimbursed Provider $13,517.97 and denied the rest. Provider requested medical fee dispute resolution seeking additional reimbursement of $1,799.65, which the Division awarded to Provider.

C. Evidence and Argument

In its bill for services, Provider utilized the following CPT codes:

CPT 29879:	abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture.
CPT 29881:	with meniscectomy (medial or lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed.
CPT 29888:	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction.

Carrier reimbursed Provider for charges associated with CPT 29881 and 29888. Richard Ball, Carrier's Senior Dispute Analyst, testified that Carrier did not dispute the Division's calculations contained in the MFDR Decision, nor did it argue that the procedure billed under CPT 29879 was not properly documented. Instead, Mr. Ball testified, Provider improperly billed for CPT 29879 pursuant to a notation in the 2012 CPT Codebook, which instructs providers that CPT 29879 cannot be reported if CPT 29881 is utilized for the same procedure.

The notation in question is located directly above CPT 29879 and states: "*when performed with arthroscopic meniscectomy, see 29880 or 29881*."[1] (Emphasis added) Mr. Ball asserted the notation directs a provider who seeks to utilize CPT 29879 to refer to CPTs 29880 or 29881.

Mr. Ball explained that CPT 29881 instructs a provider that an abrasion arthroplasty (CPT 29879) cannot be reported if it was performed in the same compartment of the knee as a meniscectomy (CPT 29881).[2] The operative report indicates Claimant underwent a partial medial meniscectomy (CPT 29881) and an abrasion chondroplasty (CPT 29879) of the medial femoral condoyle, and that both of these procedures were performed within the medial compartment of the knee.[3] Mr. Ball asserted that because both of these procedures were performed within the medial compartment of the knee, Provider was prohibited from utilizing CPT 28979 in its billing for services rendered to Claimant. Conversely, Mr. Ball stated, a

[1] Carrier's Ex. 5.

[2] There are three compartments of the knee: the medial, lateral, and patellofemoral.

[3] Carrier's Ex. 6.

provider may utilize both CPTs 29879 and 29881 if each procedure was performed in different compartments of the knee pursuant to the above-mentioned notation in the 2012 CPT Codebook.

Mr. Ball testified further that the Centers for Medicare and Medicaid Services (CMS) do not allow reimbursement to providers for an abrasion chondroplasty (CPT 29879) if it is performed in the same knee compartment as a meniscectomy (CPT 29881). The CMS rule for disallowing reimbursement of CPT 29879 is contained in the National Correct Coding Initiative Edits Manual. Although a copy of the rule was not offered as evidence, Mr. Ball testified the rule specifically states that if performing a chondroplasty in the same compartment as a meniscectomy, the chondroplasy is not separately reportable.

Provider did not cross-examine Mr. Ball, or offer testimony. She merely stated that Provider rendered the services to the Claimant in good faith, and urged the ALJ to consider the Division's MFDR Decision.

D. Analysis

As the party contesting the MFDR Decision, Carrier has the burden of proof. In this case, Carrier failed to prove Provider was not entitled to $1,799.65 in additional reimbursement.

The ALJ considers it more likely, based on a plain reading of the 2012 CPT Codebook, that the notation in question does not refer to CPT 29879 listed below the notation, but instead to CPT 29877, located directly above the notation. The ALJ likens the notation in question to an addendum for CPT 29877, rather than a heading for CPT 29879.

This interpretation of the notation is consistent with similar language in CPTs 29877 and 29881 that is not included in CPT 29879:

CPT code 29877	CPT code 29879	CPT code 29881
Debridement/shaving of articular cartilage (chondroplasty)[4]	abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture	with meniscectomy (medial or lateral, including any meniscal shaving) including **debridement/shaving of articular cartilage (chondroplasty),**[5] same or separate compartment(s), when performed

Because the language in CPT code 29877 is also contained in CPT 29881, the ALJ is convinced that the notation directly relates to CPT 29877. As such, the notation has no effect on CPT 29879 in that it does not direct providers who utilize CPT 29879 to refer to CPT codes 29880 or 29881 for any reason.

But, assuming Mr. Ball is correct that the notation in question refers to CPT 29879, neither the language contained in the notation or in CPTs 29880 or 29881 directs a provider not to report an abrasion arthroplasty (CPT 29879) if it was performed in the same compartment of the knee as a meniscectomy (CPT 29881). The notation merely directs a provider to see CPTs 29880 or 29881, and the language in each CPT code describes a surgical procedure.[6] Neither CPT code contains any language that remotely prohibits a provider from reporting CPT 29879 for any reason.

Had there been any intent to direct providers not to report or bill for CPT 29879 with CPT 29881, it likely would have been reflected in the 2012 CPT Codebook. Under other CPT codes, the 2012 CPT Codebook contains prohibitive language. For instance, page 146 of the 2012 CPT Codebook reads:

> 29866 Arthroscopy, knee surgical; osteochondral autograph(s) (e.g. mosaicplasty) (includes harvesting of the autograph(s))

[4] Emphasis added.

[5] Emphasis added.

[6] CPT 29880 reads: "with meniscectomy (medial AND lateral);" and CPT 29881 reads: "with meniscectomy (medial OR lateral)"—emphasis within text. The codes are otherwise identical.

(Do not report 29866 in conjunction with 29870, 29871, 29875, 29884 when performed at the same session and/or 29874, 29877, 29879, 29885-29887 when performed in the same compartment)

29867 osteochondral autograph (e.g. mosaicplasty)

(Do not report 29867 in conjunction with 27570, 29870, 29871, 29875, 29884 when performed at the same session and/or 29874, 29877, 29879, 29885-29887 when performed in the same compartment)

Clearly, had there been any intent to direct providers from reporting or billing for CPT 29879 in conjunction with CPT 29881, it would have been reflected. Because there is no indication in the 2012 CPT Codebook that a provider is prohibited from utilizing CPT 29879 with CPT 29881, the ALJ finds Provider did not improperly bill the services rendered under CPT 29879.

Mr. Ball also asserted that under a rule contained in the National Correct Coding Initiative Edits Manual, CMS does not allow reimbursement for providers who perform CPT 29879 if it is performed in the same knee compartment as CPT 29881. Yet, no such rule was offered as evidence, and the ALJ found no such limitation in any of Carrier's evidence. Hence, Carrier has not carried its burden of proof and the ALJ concludes that Carrier owes Provider $1,799.65 in additional reimbursement, plus any applicable interest.

III. FINDINGS OF FACT

1. On ___, services were performed at Doctors Hospital at Renaissance (Provider) in Edinburg, Texas, for an injured worker (Claimant).

2. Texas Mutual Insurance Company (Carrier) was the responsible workers' compensation insurer for the Claimant.

3. Provider billed Carrier the sum of $37,868.63 for the services provided to the Claimant.

4. Carrier reimbursed Provider $13,517.97 for the services.

5. Carrier denied Provider's request for additional reimbursement.

6. Provider timely filed a request for medical fee dispute resolution with the Texas Department of Insurance, Division of Workers' Compensation (Division).

7. On July 16, 2013, the Division issued its Medical Fee Dispute Resolution Findings and Decision (MFDR Decision), ordering Carrier to pay Provider an additional $1,799.65.

8. Carrier timely requested a hearing before the State Office of Administrative Hearings (SOAH) to contest the MFDR Decision.

9. On October 1, 2013, the Division issued a Notice of Hearing.

10. The Notice of Hearing informed the parties of the date, time, and location of the hearing; the matters to be considered; the legal authority under which the hearing would be held; and the statutory provisions applicable to the matters to be considered.

11. On November 1, 2013, a hearing convened before Administrative Law Judge Steven M. Rivas at SOAH's facilities in Austin, Texas. Carrier was represented by Bryan W. Jones, attorney. Provider's Insurance Collections Manager, Idalia Rodriguez, appeared on Provider's behalf. The record closed on the same date.

12. In its bill for services, Provider utilized Current Procedural Terminology code (CPT) 29879 abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture.

13. Provider also utilized CPT 29881 with meniscectomy (medial or lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed.

14. Provider documented in its billing to Carrier that both procedures described in CPTs 29879 and 29881 were performed.

15. There is a notation in the 2012 CPT Codebook located directly above CPT 29879, which states the following: "when performed with arthroscopic meniscectomy, see 29880 or 29881."

16. The notation is an addendum for CPT 29877, which is located directly above the notation.

17. The notation is not a heading for CPT 29879.

18. The notation does not direct providers who utilize CPT 29879 to refer to CPT 29880 or CPT 29881.

19. Neither the language contained in the notation or in CPTs 29880 or 29881 directs a provider to not report CPT 29879 if it was performed in the same compartment of the knee as CPT 29881.

20. The 2012 CPT Codebook instructs providers not to report some CPT codes in conjunction with other CPT codes.

21. The 2012 CPT Codebook does not order providers to not report CPT 29879 in conjunction with CPT 29881 or any other CPT code.

IV. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to Texas Labor Code § 413.031 and Texas Government Code. ch. 2003.

2. Adequate and timely notice of the hearing was provided in accordance with Texas Government Code §§ 2001.051 and 2001.052.

3. Carrier had the burden of proof in this proceeding.

4. The rule that sets forth the reimbursement calculation used for establishing the maximum allowable reimbursement is found in Title 28 Texas Administrative Code § 134.403.

5. No rule prohibits a provider from utilizing CPT 29879 and CPT 29881 when both services are performed during the same procedure.

6. Carrier failed to carry its burden of proving that Provider is not entitled to additional reimbursement.

7. Carrier is required to reimburse Provider the additional amount of $1,799.65, plus any applicable interest.

ORDER

IT IS ORDERED that Texas Mutual Insurance Company shall pay Doctors Hospital at Renaissance the additional sum of $1,799.65, plus any applicable interest, for the services provided to Claimant.

Texas Labor Code § 413.0312(g) and 28 Texas Administrative Code § 133.307(h) require the non-prevailing party to reimburse the Division for the cost of services provided by SOAH. Texas Labor Code § 413.0312(i) requires SOAH to identify the non-prevailing party and any costs for services provided by SOAH in its final decision. For purposes of Texas Labor Code § 413.0312, Texas Mutual Insurance Company is the non-prevailing party. The costs associated with this decision are set forth in Attachment A to this Decision and Order and are incorporated herein for all purposes.

SIGNED December 19, 2013.

STEVEN M. RIVAS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS