SOAH DOCKET NO. 454-17-4371.M4-NP
MR NO. _____

WDS, M.D.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
v.	§	
	§	**OF**
CARRIER,	§	
Respondent	§	
	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

This case involves services rendered by WDS, M.D. to an injured employee covered by the workers' compensation insurance system. The Texas Department of Insurance's Division of Workers' Compensation (Division) conducted medical fee dispute resolution (MFDR) and declined to order Carrier to reimburse Dr. S in the amount of $431.49. The Administrative Law Judge (ALJ) concludes that Dr. S is not entitled to reimbursement.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

There are no issues of notice or jurisdiction in this proceeding. Therefore, the ALJ addresses these matters in the findings of fact and conclusions of law without further discussion here.

On February 17, 2017, Dr. S filed a MFDR request with the Division.[1] On March 16, 2017, Carrier filed a response to the request by Dr. S. On April 4, 2017, the Division issued its MFDR decision, denying reimbursement. Dr. S requested a hearing at the State Office of Administrative Hearings (SOAH) to contest the Division's determination. On May 31, 2017, the Division issued a Notice of Hearing.

[1] If the Carrier still denies payment after the provider requests reconsideration, the provider may request MFDR. 28 Tex. Admin. Code § 133.240 (j).

On August 16, 2017, ALJ convened a hearing on the merits at SOAH. Carrier appeared through attorney SMT. Dr.S appeared and was represented by office manager _____. The record closed on August 31, 2017, after the parties filed additional documents and closing briefs.

As the party requesting a hearing at SOAH, Dr.S has the burden of proof to show by a preponderance of the evidence that he is entitled to reimbursement. The hearing before SOAH is a *de novo* review of the issues involved.

II. DISCUSSION

A. Applicable Law and Parties' Arguments

This case involves a very limited issue as to whether Dr. S was allowed to use modifier -59 (Distinct Procedural Service) and receive payment for use of an operating microscope (CPT[2] Code 69990-58-59) for the surgery on the small finger (left hand) of an injured worker. The entire surgery involved: a tendon repair (CPT Code 26356), artery repair (CPT Code 35207), nerve repair (CPT Code 64831), and wound repair (CPT Code 12001).[3] CPT Code 64831 (nerve) is on the add-on list for CPT Code 69990; CPT Code 35207 (artery) is not on the add-on list for CPT Code 69990. The rule at issue, 28 Texas Administrative Code § 134.203(b),[4] provides in relevant part:

> (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 shortages (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.
>
> …

[2] Current Procedural Terminology (CPT).

[3] Dr. S used modifiers for the CPT Code procedures as follows: CPT Code 26356-58; CPT Code 26356-58-59; CPT Code 35207-58-51; CPT Code 64831-58-51; CPT Code 69990-58-59; and CPT Code 12001-58-59.

[4] Subsequent references in the text to the Division's rules will be to "Rule § ___."

Carrier argues that The Centers for Medicare & Medicaid Services (CMS) policies and CCI edits do not allow separate payment for CPT Code 69990 under the facts of this procedure because payment for use of the microscope is included in relative value units (RVUs) for CPT Code 35207 (artery repair), and likely CPT Codes 26356 (tendon repair) and 12001 (wound repair).[5] In other words, because Dr. S's surgery involved repair of the artery, tendon, and wound, he already received payment for the use of the microscope—a cost included in these procedures. If Dr. S received additional payment for the microscope, Carrier contends that he would be over-recovering for use of the microscope for the nerve repair.

Moreover, Carrier argues that additional recovery is not allowed because the nerve repair is on the add-on list for CPT Code 69990, but the artery repair is not on the list for CPT Code 69990. According to Carrier, if Dr. S used the microscope for two procedures but only one of the procedures (the nerve repair) is on the CMS list for which CPT Code 69990 is separately payable, payment for CPT Code 69990 may be denied because Dr. S attempted to bundle CPT Code 69990 into a procedure (the artery repair) not on the CMS list. Finally, Carrier claims that any request to circumvent Rule § 134.203(b) would require the use of modifier -22 and appropriate documentation, not modifier -59. Therefore, according to Carrier, Dr. S used an outdated and inappropriate modifier.

Dr. S recognizes that the CCI edits do not allow payment for the add-on CPT Code 69990 with CPT codes 26356 (tendon) and 35207 (artery), but he argues that Medicare does allow payment for CPT Code 69990 with CPT Code 64831 (nerve). Dr. S insists that CPT Code 69990 is an add-on code that is eligible for payment with CPT Code 64831 (nerve), and it does not matter that other CPT Codes were used (for example, CPT Codes 26356 and 35207). Because CPT Code 64831 (nerve repair) was the primary code and is on the add-on list, Dr. S argues that it does not matter that other CPT Codes are not on the add-on list. Dr. S also contends that it was appropriate to use modifier -59 to differentiate the various procedures.

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[5] RVUs are a measure of value used for the Medicare reimbursement formula for physician services.

B. Evidence

Neither party presented testimony in this case. Carrier submitted documentation consisting of: Medical Fee Dispute Resolution Findings and Decision; Medical Fee Benefit Review Conference Report; Carrier's explanation of benefits (EOB) and CCI Edit Worksheets; Carrier's Response to Request for Medical Fee Dispute Resolution; Corvel's Response to Request for Medical Fee Dispute Resolution; Chapter VIII, CCI Edits, Subsection F. "Operating Microscope" Revision Date (Medicare) 1/1/2016 (excerpt); Modifier 59 Article (CMS) (excerpt); and additional documentation on uses of modifiers. (Exhibits 1 through 8). Dr. S submitted documentation relating to his position and on all pages were marked as Dr. S Exhibit 1.

One of Dr. S's patients suffered a laceration to his left small finger, which resulted in injury to the blood vessel, tendons, artery, and nerves. On October 28, 2016, Dr. S billed Carrier for medical procedures involved to repair the lacerated finger performed on October 27, 2017. Carrier paid most of the claim; however, Carrier did not pay for the add-on CPT Code 69990 (use of the microscope). Carrier issued an EOB to Dr. S using the following code for nonpayment:

> 236 This procedure or modifier combination is not compatible with another procedure on the same day

C. ALJ's Analysis

The Division found that Dr. S was not entitled to reimbursement for CPT Code 69990 because is already included in the allowance of CPT Codes 12001 and 26356. Furthermore, it found that use of modifier -59 to CPT Code 69990 is not allowed to differentiate the various procedures and allow for additional recovery under the facts in this case. Rule § 134.203(b).

The ALJ finds that Dr. S failed to meet the burden of proof by a preponderance of evidence to show that he was entitled to additional reimbursement. The use of the microscope (CPT Code 69990) was already bundled into the RVU for other procedures, specifically CPT Code 26356—the tendon repair; therefore, Dr. S recovered his costs for the use of the microscope. In addition, CPT Code 64831 (the nerve repair) cannot be bundled with CPT Code 35207 (the artery repair) because the artery repair is not on the add-on list for CPT Code 69990.

Finally, Dr. S's argument that modifier -59 was appropriate because nerve repair, was somehow unconnected to the tendon, artery, and wound procedures is not persuasive. Modifier -59 would only be used if the provider was seeking payment for separate and distinct procedures, not typically performed at the same time. In this case, the finger surgery (wound, tendon, artery, and nerve) was performed at the same time as one procedure. In other words, use of modifier -59 would only be allowed if Dr. S could show that the tendon, artery, nerve, and wound repair were different procedures not performed on the same day by the same doctor. He failed to prove that use of modifier -59 was appropriate. Even if the procedures were distinct and separately performed, Dr. S used the incorrect modifier. Under the facts in this case, the appropriate modifier would have been -22. The ALJ finds the MFDR decision was correct. Therefore, Carrier is not ordered to reimburse Dr. S the amount of $431.49 for the services in dispute in this case. In support of this determination, the ALJ makes the following findings of fact and conclusions of law.

III. FINDINGS OF FACT

1. On October 27, 2017, Dr. S, M.D., performed surgery on the left small finger of an injured worker.

2. Carrier paid for most of the procedures involved in the surgery but declined to reimburse Dr. S for $431.49.

3. Carrier issued an explanation of benefits to Dr. S, stating that the procedure or modifier combination was not compatible with another procedure on the same day.

4. On February 17, 2017, Dr. S timely filed a request for medical fee dispute resolution (MFDR) with the Texas Department of Insurance, Division of Workers' Compensation (Division).

5. On April 4, 2017, the Division issued its MFDR Findings and Decision (MFDR Decision), ordering that Carrier was not required to reimburse Dr. S the amount in dispute.

6. Dr. S timely requested a hearing before the State Office of Administrative Hearings (SOAH) to contest the MFDR Decision.

7. The notice of hearing contained a statement of the time, place, and nature of the hearing;

a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and a short, plain statement of the factual matters asserted.

8. On August 16, 2017, a hearing convened before Administrative Law Judge at SOAH's facilities in Austin, Texas. Dr. S was represented by office manager_____. Carrier was represented by attorney SMT. The record closed on August 31, 2017, after the parties filed post-hearing briefs and other documents.

IV. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order. Tex. Lab. Code § 413.031; Tex. Gov't Code ch. 2003.

2. Adequate and timely notice of the hearing was provided. Tex. Gov't Code §§ 2001.051, 2001.052.

3. Under 28 Texas Administrative Code § 134.203(b), "[f]or 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. . . .

4. Dr. S had the burden of proving by a preponderance of the evidence that he was entitled to additional reimbursement. 1 Tex. Admin. Code § 155.427.

5. Dr. S failed to prove he billed, coded, and modified the finger surgery as required under 28 Texas Administrative Code § 134.203(b).

6. Because Dr. S failed to carry his burden of proof, the ALJ finds that Dr. St has not shown he is entitled to additional reimbursement; therefore, Carrier is not required to reimburse Dr. S in the amount of $431.49.

ORDER

IT IS ORDERED that Carrier is not required to reimburse Dr. S the requested $431.49.

NON-PREVAILING PARTY DETERMINATION

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, Dr. S is the non-prevailing party. The costs associated with this decision are set forth in the Statement of Costs attached to this Decision and Order and are incorporated herein for all purposes.

SIGNED October 5, 2017.

MICHAEL J. O'MALLEY
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARING