MDR Tracking Number: M5-03-0685-01

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 11/5/02.

I. DISPUTE

Whether there should be reimbursement for manipulation of spine 22505, fixation of shoulder 23700, manipulation of hip joint 27275, fixation of knee joint 27570, post operative monitoring 99499 RR, anesthesia supplies 99070 AS, assistant surgeon charges for manipulation of spine 22505-80, fixation of shoulder 23700-80, manipulation of hip joint 27275-80, fixation of knee joint 27570-80. These services were denied payment by the respondent based upon "F" reduced or denied in accordance with TWCC Medical Fee Guideline Ground Rules." After reconsideration on 1/22/02, the respondent added that "The charges were performed in a doctor's office, not an ambulatory surgical center or hospital setting as indicated by the place of service on the billing, therefore all services related to that procedure is considered unnecessary. The services performed in the doctor's office were denied per the 04/01/96 TWCC Medical Fee Guideline, Surgery Ground Rule V,B,2."

Because the carrier denied the dispute on the basis of "U – unnecessary treatment", this dispute was originally established by the Commission as a medical necessity dispute. After clarification by the carrier that the denial is based on the services being performed in a doctor's office, this dispute was deemed a medical fee dispute and is being reviewed on that basis.

II. RATIONALE

The 04/01/96 TWCC Medical Fee Guideline, Surgery Ground Rule (V)(B)(2) states, "If the services (99070-AS) require the use of complex or prolonged anesthesia or the need for an anesthesiologist or CRNA, the service shall be performed in a hospital or ambulatory surgical center. This service is billed using code 99070-AS". The anesthesia supplies 99070-AS were provided in a doctor's office. Therefore, disputed service 99070-AS is not reimbursable.

The post operative monitoring 99499 RR per the Medical Fee Guideline, Surgery Ground Rules (V)(B)(3) states, "Postoperative monitoring is reimbursed hourly. The service is billed using code 99499-RR…The maximum amount of time allowed for postoperative monitoring is four hours and DOP is required." The medical documentation supported two hours of postoperative monitoring.

The 1996 MFG General Instructions Ground Rule III (A) states that "Documentation of Procedure (DOP) in the maximum allowable reimbursement (MAR) column indicates that the value of this service shall be determined by written documentation attached to or included in the bill. DOP is used when the services provided are not specifically listed or are unusual or too

variable to have an assigned MAR. The required documentation may vary based on the complexity of the procedure. DOP shall include pertinent information about the procedure including:

1. Exact description of procedure or service provided;
2. Nature, extent, and need (diagnosis and rationale for the service or procedure;
3. Time required to perform the service or procedure;
4. Skill level necessary for performance of service or procedure;
5. Equipment used (if applicable): and
6. Other information as necessary.

The requestor furnished information giving a description of service provided, nature, extent and need (diagnosis and rationale) for the service or procedure, time required to perform the service and equipment used. The post operative monitoring medical documentation provided sufficient DOP. Reimbursement is recommended.

The Commission's Medical Fee Guideline, Medicine Ground Rules, (I)(D)(1)(3) states, "The following body areas are recognized for the provision of physical medicine…

a. Head
b. Lower Extremity...
c. Upper extremity…
d. Trunk…
e. Spine (which is divided into four regions:…

If the physical medicine code states "one or more areas" but has no time limit, then only one unit can be charged regardless of the number of body areas treated…"

On this basis, the manipulations under anesthesia 22505, 23700, 27275 and 27570 are reimbursable for one area each.

The services for the "modifier–80 assistant surgeon" are supported by TWCC Advisory 92-09B which states, "Manipulation of the spine under anesthesia, CPT code 22505, is a non-invasive procedure, but by individual facility protocol may require a chiropractic first assistant. When required by facility protocol, the chiropractic first assistant will be reimbursed as an assistant surgeon at 20% of the RVU, and modifier –80 must be indicated on the bill…" The medical documentation supports the delivery of services of an assistant surgeon, therefore 22505-80, 23700-80, 27275-80 and 27570-80 should be reimbursed.

III. DECISION & ORDER

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor **is** entitled to reimbursement for 22505, 23700, 27275 and 27570, 22505-80, 23700-80, 27275-80 and 27570-80 and 99499-RR in the amount of **$3,120.00.** Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby ORDERS the

Respondent to remit **$3,120.00** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Findings, Decision and Order are hereby issued this 31st day of October, 2003.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/nlb