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 8-4-03.

I. DISPUTE

Whether there should be reimbursement for 63047, 63048 x 2, 22899 x 3, 22612-51, 22650 x 2, 22842, and 22820 billed on 4-25-03 and denied by the carrier as unnecessary medical.

II. RATIONALE

On 10-28-03, a Notice was issued stating that the Division determined that the issues in dispute are related to reimbursement based on fee issues only. Per Rule 133.307(g)(3), the Notice also requested the requestor to submit additional documentation necessary to support the fee charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The requestor submitted preauthorization letter # 450405-1646808 that authorized lumbar spine fusion @ L3-S1 with decompression instrumentation and graft for 3 days and preauthorization letter # 450405-1648574 that authorized one additional day. Rule 133.301(a) states that a carrier shall not retrospectively review the medical necessity of a medical bill for treatment and or service that were preauthorized under 134.600 (h). Therefore, this review will be according to the 1996 *Medical Fee Guideline.*

Recommend reimbursement of $3,540.00 for primary code 63047.

The *Medical Fee Guideline* Surgery ground rule I. D. 2. states that some procedures such as 63048, 22650, 22842, and 22820 are already reduced and shall not be further reduced per the multiple procedure rule. Recommend reimbursement of $708.00 + $708.00 + $637.00 + $637.00 + $3400.00 + $425.00 = $6,515.00.

Modifier –51 is used when multiple procedures are performed on the same day. Per the multiple procedures rule, the secondary procedure identified with the –51 modifier is reimbursed at 50% of the MAR. Recommend reimbursement of $1,264.50 for code 22612-51.

Code 22899 with a MAR of DOP was denied as "V"; however, this procedure was preauthorized. The carrier raised no other issues. Therefore, recommend reimbursement of $3100.00 x 3 = $9,300.00.

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. Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby ORDERS the Respondent to remit $20,619.50 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 18th day of June 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

David R. Martinez, Manager
Medical Dispute Resolution
Medical Review Division