MDR Tracking Number: M4-05-0818-01

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 9-28-04.

I. DISPUTE

Whether there should be reimbursement for CPT code 37799-62 rendered on 10-1-03.

II. FINDINGS

Review of the requestors' position statement dated 10-15-04, states in part, "…This portion of the operative procedure requires skill, experience and knowledge of techniques involving soft tissue only, major arterial and venous structures, and viscera that normally lie intimately along the anterior aspect of the thoracic and lumbosacral spine. The requestor performs an anterior extraperitoneal exposure of the spine…We billed our procedure under CPT Code 37799 (unlisted vascular) since there was no specific code to reflect his operative contribution in the treatment of disease of the spinal column…As there is no established maximum set by the commission for this code, I am enclosing twelve copies of explanation of benefits of different workers compensation insurance to demonstrate and justify this amount sought for as fair and reasonable…"

Review of the respondent's position statement dated 10-20-04, states in part, "…The Provider billed the primary procedure as vascular surgery and added modifier-62, which is used when two surgeons are required to manage a specific surgical procedure. A prior SOAH decision has held that the opening and closing for an anterior arthrodesis is not a separate procedure. Carrier maintains that the documentation fails to support 37799 and is included as a global service."

Section 413.011 (d) states that the guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. Rule 133.307(g)(3)(D), if a dispute involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with Rule 133.1. The carrier did not question fair and reasonable reimbursement for a code with no MAR per Rule 133.1(8).

III. RATIONALE

Rule 133.304(c) states that the explanation of benefits shall provide sufficient explanation to allow the sender to understand the reason for the carrier's action. The carrier used PECs "O", "G", and "N".

For denial code "N – documentation fails to support 37799 vs 49000": Per the Ingenix EncoderPro, code 49000 is for exploratory laparotomy. The attending physician's operative report states the procedure performed was a partial corpectomy and fusion @ L5 and S1. The report also stated that the Requestor performed a retroperitoneal approach through a transverse incision to gain access to the anterior spine. After the attending physician performed the operation, the Requestor proceeded with the closure. The Requestor's operative report states he performed an anterior extraperitoneal exposure of vertebral bodies L5-S1. The operative report states that after the orthopedic surgery team performed their portion of the operation, the Requestor closed. Documentation supports services rendered. Therefore, recommend reimbursement.

For denial code "G – per global service data, surgical approach, with necessary identification, isolation, and protection of anatomical structures…are included in global services package." Per 133.304(c), a generic statement that simply states a conclusion such as 'not sufficiently documented" or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section. The carrier did not state what the disputed service was global to and the Division is unable to determine what the disputed service is global to. Therefore, recommend reimbursement.

For denial code "O – opening and closing is global of performed procedure. Documentation fails to support vascular surgery billing." Per 133.304(c), a generic statement that simply states a conclusion such as 'not sufficiently documented" or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section. The carrier did not state what the disputed service was global to and the Division is unable to determine what the disputed service is global to. Operative report supports services rendered. Therefore, recommend reimbursement.

The requestor submitted redacted copies of EOBs (same diagnosis code) showing the average fee charged for procedure code 37799 was $9000.00 and the average reimbursement was $7,687.50. The requestor billed $9500.00 and is seeking $6,861.00. Recommend reimbursement of $6,861.00.

The above Decision is hereby issued this 17th day of February 2005.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

IV. 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 CPT code 37799-62 in the amount of **$6,861.00.** Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby ORDERS the Respondent to remit **$6,861.00** 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 17th day of February 2005.

Medical Dispute Resolution
Medical Review Division