Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS ORTHOPEDIC HOSPITAL
7401 S MAIN STREET
HOUSTON TX 77030-4509

Respondent Name
Wausau Underwriters Insurance

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-12-1961-01

MFDR Date Received
February 7, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier didn't pay according to the 16% we should be reimbursed for an assist. 22 modifier indicates the complex of the procedure."

Amount in Dispute: $146.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT 63081 Modifier 22 was not paid at a higher rate because the modifier used, was not supported. When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (***i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required.*** The operative report submitted for the 08/15/2011 does not document increase intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required. Liberty Mutual believes that Steven Hammerman has been appropriately reimbursed for services rendered…"

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 15, 2011	Professional Services	$146.12	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.20 sets out requirements for medical bill submission by health care providers.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

- X073 – ASSISTANT SURGEON NOT CUSTOMARY FOR THIS PROCEDURE
- X901 – DOCUMENTATION DOES NOT SUPPORT LEVEL OF SERVICE BILLED
- X598 – CLAIM HAS BEEN RE-EVALUATED BASED ON ADDITIONAL DOCUMENTATION SUBMITTED; NO ADDITIONAL PAYMENT DUE.

Issues

1. Did the requestor support use of the 59 modifier?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.20(b)(1) states, in pertinent part, "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; …and other payment policies in effect on the date a service is provided…" The medical bill for the service in dispute included the "22" modifier. American Medical Association Current Procedure Terminology (AMA CPT) describes the 22 modifier for use in identifying procedural services when the work required in providing the service is substantially greater than typically required. Documentation must support the substantial additional work and the reason for the additional work (i.e. increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Review of the procedure described in the document titled "OPERATIVE REPORT" does not meet the requirements of 28 Texas Administrative Code §133.20(b)(1).
2. The requestor billed 63081 -22. The requestor did not support use of the 22 modifier; consequently no additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 25, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.