



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

FONDREN OTHROPEDIC GROUP, LLP

Respondent Name

TRANSPORTATION INSURANCE CO

MFDR Tracking Number

M4-15-1417-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

JANUARY 12, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The surgeons did bill with the 22 modifier to indicate the complexity of this procedure and is documented in the coded operative report."

Amount in Dispute: \$1,281.59

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Regarding the use of Modifier 22, Carrier does not dispute that use of modifier 22 is supported by submitted documentation evidencing that the procedure took twice as long as usual due to the patient's size, contracture and complex closure. As demonstrated, the fee schedule amount for CPT 27487-22 is \$3,445.26. The Requestor, per the Table of Disputed Services is seeking \$4,431.58. The Requestor is seeking the fee schedule amount plus an additional 25% based on modifier 22. Carrier asserts that the Requestor has failed to support the request for additional 25% payment above MAR for CPT 27487-22...As demonstrated, the fee schedule amount for CPT 27487-AS-22 is \$482.15...It is Carrier/Respondent's position that the request for additional reimbursement is not supported. The requestor has not demonstrated or justified that payment of the amount sought would be fair and reasonable rate of reimbursement for the services in dispute."

Response Submitted by: Law Office of Brian J. Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 18, 2014	CPT Code 27487-AS-22-LT Physician Assistant Services for Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component	\$218.59	\$0.00
	CPT Code 27487-22-LT Surgeon Services for Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component	\$1,063.00	\$0.00
TOTAL		\$1,281.59	\$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, effective May 25, 2008, 33 *Texas Register* 3954, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 set out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 *Texas Register* 626, provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - P12-Workers' compensation jurisdictional fee schedule adjustment.
 - P300-The amount paid reflects a fee schedule reduction.
 - MT12-Diagnosis Code indicates severe injury.
 - MT21-Provider bill with charges over \$5,000.00.
 - Z710-The charge for this procedure exceeds the fee schedule allowance.
 - W3-Request for reconsideration.

Issues

1. Did the requestor's documentation support billing modifier 22?
2. Did the requestor support position that additional reimbursement is due for code 27487-AS-LT per 28 Texas Administrative Code §134.1?
3. Did the requestor support position that additional reimbursement is due for code 27487-AS-LT per 28 Texas Administrative Code §134.1?

Findings

1. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

On the disputed date of service, the requestor billed CPT codes 13121-59, 13122-59, 27335-LT, 27487-22-LT, and 27487-AS-22-LT. The services in dispute are: 27487-22-LT and 27487-AS-22-LT.

The requestor appended modifiers:

- "LT-left side."
- "22-Increased Procedural Services" defined as "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 (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required)."
- AS-"Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery."

The requestor noted in the Operative Report that "The patient was of added complexity due to his morbid obesity with a BMI of 57.8, needed additional time for positioning, exposure, handling of the limb and the soft tissues, and additional time for soft tissue closure. This will be billed as a complex procedure due to doubling the time needed to do a standard revision knee."

The respondent states "Regarding the use of Modifier 22, Carrier does not dispute that use of modifier 22 is supported by submitted documentation evidencing that the procedure took twice as long as usual due to the patient's size, contracture and complex closure."

The Division finds that the requestor's documentation supports the use of modifier 22.

2. The requestor billed \$7,813.00 for code 27487-22-LT. The respondent paid \$3,545.26. The requestor is seeking additional reimbursement of \$1,063.00 for the additional services billed with modifier 22. Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the

established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

Place of Service is 21-Inpatient Hospital.

The 2014 DWC conversion factor for this service is 69.98.

The Medicare Conversion Factor is 35.8228

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77030, which is located in Houston, Texas; therefore, the Medicare participating amount is based on locality "Houston Texas".

Medicare Participating amount for code 27487 is \$1,814.82.

Using the above formula, the Division finds the following: MAR is \$3,545.26. Based upon the submitted explanation of benefits, the respondent paid \$3,545.26 for code 27487-22-LT.

The requestor contends that additional reimbursement of \$1,063.00 is due because of the increased services required and supported by modifier 22.

The *Medicare Claims Processing Manual* Chapter 12 §20.4.6 entitled *Payment Due to Unusual Circumstances (Modifiers "-22" and "-52")*, Rev. 1, 10-01-03, B3-15028, states that "The fees for services represent the average work effort and practice expenses required to provide a service. For any given procedure code, there could typically be a range of work effort or practice expense required to provide the service. Thus, carriers may increase or decrease the payment for a service only under very unusual circumstances based upon review of medical records and other documentation."

The *Medicare Claims Processing Manual* Chapter 12 §40.2.A.10 entitled *Unusual Circumstances*, Rev. 1, 10-01-03, B3-4822, defines "Surgeries for which services performed are significantly greater than usually required may be billed with the '-22' modifier added to the CPT code for the procedure."... "The biller must provide:

- A concise statement about how the service differs from the usual; and
- An operative report with the claim.

Modifier '-22' should only be reported with procedure codes that have a global period of 0, 10, or 90 days."

The *Medicare Claims Processing Manual* Chapter 12 §40.4.A. entitled *Fragmented Billing of Services Included in the Global Package*, Rev. 1, 10-01-03, B3-4824, B3-4825, B3-7100-7120.7, provides, in relevant part, that "Claims for surgeries billed with a "-22" or "-52" modifier, are priced by individual consideration if the statement and documentation required by §40.2.A.10 are included."

When the provider has billed for services that Medicare does not assign a relative value unit or payment, 28 Texas Administrative Code §134.203(f) states "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."

28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable." Review of the submitted documentation finds that:

- The requestor does not discuss or demonstrate how additional reimbursement of \$1,063.00 reimbursement for code 27487-22-LT is a fair and reasonable reimbursement.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.

- The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended

3. The requestor billed \$1,954.00 for code 27487-AS-22-LT. The respondent paid \$482.15. The requestor is seeking additional reimbursement of \$218.59 for the additional services billed with modifier 22. The requestor appended modifier AS. Per Medicare Surgery Policy Manual, the PA for assistant at surgery receives 85 percent of 16 percent of the MAR. Therefore, the MAR for 27487-AS is 85 percent of 16 percent of \$3,545.26 = \$482.15. The respondent paid \$482.15.

The requestor contends that additional reimbursement of \$218.59 is due because of the increased services required and supported by modifier 22.

As stated above, when the provider has billed for services that Medicare does not assign a relative value unit or payment reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).

In addition, 28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title.” Review of the submitted documentation finds that:

- The requestor does not discuss or demonstrate how additional reimbursement of \$218.59 reimbursement for code 27487-AS-22-LT is a fair and reasonable reimbursement.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot 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

07/01/2015
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).

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