



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Fondren Orthopedic GP LLP

Respondent Name

Hartford Fire Insurance Company

MFDR Tracking Number

M4-15-1868-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

February 20, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have received your payment for codes 28725/22/RT on main surgeon and are not arguing that the payment was not the contractual amount. However we are asking there to be a consideration for additional payment in addition to the allowed amount for the use of the 22 modifier (complex case). **The surgeons did bill with the 22 modifier to indicate that the services they had provided were greater than that usually required for the listed procedure.** We are requesting a review by a **Qualified Medical Director who is knowledgeable in the coding and billing for orthopedic surgeons.**

The physician has noted in the operative report that the modifier 22 – Tenotomies were used to perform an extensive synovectomy, as there was significant inflammatory tissue around tendons. Then elevated the periosteum along his lateral calcaneus, and a ½ inch curved fibula. Once this was complete the lateral calcaneus was further contoured using a power rasp."

Amount in Dispute: \$778.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our investigation has found that reimbursement was made in accordance with Rule 134.203.

The provider has stated that *'The surgeons did bill with the 22 modifier to indicate that the services they had provided were greater than that usually required for the listed procedure.'* However, the carrier does not show a record of receipt of billing from the assistant surgeon to support eh above statement..."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 7, 2014	Arthrodesis; subtalar – increased procedural service (28725-22)	\$778.30	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 §134.203 sets out the fee guidelines for billing and reimbursing professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12 – Workers' compensation jurisdictional fee schedule adjustment.
 - 4063 – Reimbursement is based on the Physician Fee Schedule when a professional service was performed in the facility setting.
 - 193 – Original payment decision is being maintained. This claim was processed properly the first time.
 - 1115 – We find the original review to be accurate and are unable to recommend any additional allowance.

Issues

1. Did the requestor support the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code P12 – "Workers' compensation jurisdictional fee schedule adjustment," and 4063 – "Reimbursement is based on the Physician Fee Schedule when a professional service was performed in the facility setting." 28 Texas Administrative Code §134.203 is the appropriate fee schedule guidelines to review the disputed service and requires that "(b) 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; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

The American Medical Association (AMA) CPT code definition for 28725 is: "Arthrodesis; subtalar," which is described further as, "The physician fuses the subtalar (talocalcaneal) joint. An incision is made over the lateral ankle and foot. The physician extends this incision deep to the subtalar joint. Tendons and nerves are retracted and protected. Soft tissues are debrided. The joint capsule is incised and the joint is debrided as necessary. Surgical instruments including curettes are utilized to remove the articular cartilage of the joint. Fixation devices such as screws, pins, or wires are employed to maintain fixation of the talus. The incision is closed in layers. A cast is typically applied."

Modifier 22 is 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). Note: This modifier should not be appended to an E/M service" [emphasis added].

Review of the submitted information finds that documentation does not support how the services were substantially increased above normal services. Therefore, the requestor did not support the disputed services.

2. Because the requestor did not support the disputed services, no further reimbursement is 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

_____	_____ Laurie Garnes _____	_____ May 13, 2015 _____
Signature	Medical Fee Dispute Resolution Officer	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, 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 MFDR 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.