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 Group

Respondent Name
Travelers Indemnity Company

MFDR Tracking Number
M4-16-1242-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
January 11, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The physician has noted in the operative report that the modifier 22 was used for the difficulty of the procedure due to the additional amount of work needed to be done for preparation using revision type components for a primary knee."

Amount in Dispute: $1313.09

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier contends the Provider is not entitled to additional reimbursement."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 6, 2015	Total Knee Arthroplasty (27447-22)	$1313.09	$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 §134.1 sets out the procedures for medical reimbursement.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.
   - W3 – Additional payment made on appeal/reconsideration.

- 1115 – We find the original review to be accurate and are unable to recommend any additional allowance.

Issues

Did the requestor support position that additional reimbursement is due for code 27447-22-RT per 28 Texas Administrative Code §134.1?

Findings

The requestor billed $6250.00 for procedure code 27447-22-RT. The insurance carrier paid $2783.89. The requestor is seeking an additional reimbursement of $1313.09. The procedure is defined as follows:

- 27447 – Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty).
- Modifier "22" – Increased procedural services: 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).
- Modifier "RT" – Right side

The place of service on the HICF Form 1500 is "21," which represents an inpatient hospital service. 28 Texas Administrative Code §134.203(c) states,

> 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 Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. The Division conversion factor for surgery in a facility setting for 2015 is $70.54.

For procedure code 27447 on August 6, 2015, the relative value (RVU) for work of 20.72 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 21.113680. The practice expense (PE) RVU of 14.35 multiplied by the PE GPCI of 1.006 is 14.436100. The malpractice (MP) RVU of 4.10 multiplied by the MP GPCI of 0.955 is 3.915500. The sum of 39.465280 is multiplied by the Division conversion factor of $70.54 for a MAR of $2783.88.

Submitted documentation finds that the insurance carrier paid $2783.89. The requestor argues that an additional $1313.09 is due because of the increased services required and supported by modifier 22. The Medicare Claims Processing Manual Chapter 12 §20.4.6 states,

> 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 states,

> 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. provides 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. If the statement and documentation are not submitted with the claim, pricing for "-22" is it the fee schedule rate for the same surgery submitted without the "-22" modifier.

28 Texas Administrative Code §134.203(f) requires that

> 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…

28 Texas Administrative Code §134.1 states, in relevant part:

(e) Medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with:
  (1) the Division's fee guidelines;
  (2) a negotiated contract; or
  (3) in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section.

(f) Fair and reasonable reimbursement shall:
  (1) be consistent with the criteria of Labor Code §413.011;
  (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
  (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

Because the Division's fee guidelines do not address the relative value unit or payment of the additional reimbursement for modifier "22," and no documentation was provided to support that a negotiated contract exists for this additional amount, reimbursement is subject to the fair and reasonable requirements of 28 Texas Administrative Code §134.1(f). 28 Texas Administrative Code §133.307(c)(2)(O) requires that the requestor 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 … 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 did not submit documentation that discusses, demonstrates, or justifies that the additional reimbursement of $1313.09 is a fair and reasonable rate of reimbursement for the disputed procedure code 27447-22-RT;
- the requestor did not provide documentation to support 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; and
- 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

	Laurie Garnes	February 24, 2016
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.