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
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-16-3336-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
JUNE 30, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please be advised that this letter is to justify the use of a 22 modifier for complex or difficult procedure during implantation of the reverse prosthesis during a primary arthroplasty as well as a revision arthroplasty. The implantation of the reverse shoulder prosthesis is currently a procedure without a specific code. Although it is a total shoulder arthroplasty is indefinitely more complex and difficult than performing a typical unconstrained shoulder arthroplasty. The dissection when implanting the reverse prosthesis is more detailed and complex as these patients have more severe deformity as they have chronic rotator cuff insufficiency which leads to morphological changes of both the humerus and the glenoid making identification of anatomical structures more difficult during the implantation of this device. Additionally, many of these patients have pre-existing scar tissue from rotator cuff tearing that does not occur in most cases of unconstrained shoulder arthroplasty. This leads to increased operative time in the neighborhood of 25% longer than a normal total shoulder in my practice. Additionally, the follow-up that occurs in the global period is more detailed."

Amount in Dispute: $1,447.84

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor seeks additional reimbursement, beyond the MAR, for code 23474, revision of humeral and glenoid component of a total shoulder arthroplasty. In his April 12, 2016 letter in the DWC60 the requestor gives two reasons for this. First, 'The dissection when implanting the reverse prosthesis is more detailed and complex as these patients have more severe deformity as they have chronic rotator cuff insufficiency which leads to morphological changes of both the humerus and the glenoid making identification of anatomical structures more difficult during the implantation of this device.' His operative report is silent about the state of rotator cuff insufficiency. Second, 'Additionally, many of these patients have pre-existing scar tissue from rotator cuff tearing that does not occur in most cases of unconstrained shoulder arthroplasty.' There is nothing about this in the operative report. In fact the only documented obstacle was a subdeltoid contracture. No additional payment is due."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 27, 2016	CPT Code 23474-22-RT	$1,302.16	$0.00
	CPT Code 23474-22-80-RT	$145.68	$0.00
TOTAL		$1,447.84	$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 a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
   - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(b) states "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…"

   The Requestor billed CPT code "23474-Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component."
   - The requestor appended modifier "22-Increased Procedural Services" to CPT code 23474 on Dr. Thomas Edward's bill.
   - The requestor appended modifier "80-Assistant Surgeon" and "22-Increased Procedural Services" on Dr. Steven Hammerman's bill.

2. 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).

The 2016 DWC conversion factor for this service is 71.32.

The Medicare Conversion Factor is 35.8043

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".

The Medicare participating amount $1,828.45.

Using the above formula, the Division finds the MAR for surgeon's bill is $3,642.16. The respondent paid $3,642.15. The difference between the MAR and amount paid is $0.00.

Per Medicare Surgery Policy Manual, "The allowed amount for assistant-at-surgery services is 16 percent of the physician fee schedule."

Using the above formula, the Division finds the MAR for assistant surgeon's bill is $3,642.16 X 16% = $582.75. The respondent paid $582.75. The difference between the MAR and amount paid is $0.00.

3. The requestor appended Modifier "22-Increased Procedural Services" which 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)."

   A review of the submitted documentation finds that the requestor underlined the circumstances in the Operative Report why modifier 22 was used.

4. The requestor is seeking a greater reimbursement than the MAR allowance for code 23474 and 23474-80 by appending 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 "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."

5. The *Medicare Claims Processing Manual* Chapter 12 §40.2.A.10 entitled *Unusual Circumstances*, Rev. 2997, effective: upon implementation of ICD-10, provides that "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 Division finds that modifier 22 can be reported with CPT code 23474 because it has a global period of 90 days. The requestor did submit an operative report, but did not provide a concise statement about how the services performed are significantly greater from the usually required for the procedure.

6. The *Medicare Claims Processing Manual* Chapter 12 §40.4.A. entitled *Fragmented Billing of Services Included in the Global Package*, Rev. 2997, effective: upon implementation of ICD-10, 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."

   Modifier 22 does not have a relative value assigned in the fee schedule.

7. Per 28 Texas Administrative Code §134.203(f), states 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 (relating to Medical Reimbursement).

   Where the provider has billed for services for which no relative value unit or payment has been assigned by Medicare, Division rule at 28 TAC §134.203(f) provides that such services shall be reimbursed in accordance with Division rule at 28 TAC §134.1.

8. 28 Texas Administrative Code §134.1, requires that, in the absence of an applicable fee guideline, medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with §134.1(f) which states that "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."
9. 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." The Division reviewed the documentation submitted by the requestor and finds:
    - The requestor does not discuss or demonstrate how the additional payment of $1,302.16 for code 23474-22-RT and $145.68 for 23474-80-22-RT would result in a fair and reasonable reimbursement.
    - The requestor does not discuss or demonstrate how additional payment of $1,302.16 and $145.68 would result in a fair and reasonable reimbursement.
    - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
    - The requestor did not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.
    - 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, published Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments to support the proposed methodology.

    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. The Division therefore finds that the requestor is not entitled to additional reimbursement.

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

		08/04/2016
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.