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**
THOMAS BRADLEY EDWARDS, MD

**Respondent Name**
INDEMNITY INSURANCE COMPANY OF NORTH AMERICA

**MFDR Tracking Number**
M4-18-3976-01

**Carrier's Austin Representative**
Box Number 15

**MFDR Date Received**
June 13, 2018

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary**: "Although it is a total shoulder arthroplasty, it is infinitely more complex and difficult than performing a typical unconstrained shoulder arthroplasty. . . . Additionally, the follow-up that occurs in the global period is more detailed . . ."

**Amount in Dispute**: $978.09

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary**: "The Carrier has reviewed the documentation and determined the Provider was properly reimbursed under the Division-adopted fee schedule."

**Response Submitted by**: Constitution State Services

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Dispute Amount | Amount Due |
|---|---|---|---|
| August 9, 2017 | Outpatient Hospital Services | $978.09 | $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 §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §134.1 sets out general provisions regarding medical reimbursement.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 126 – ASSISTANT SURGEON REIMBURSEMENT AT 16% OF PRIMARY SURGEON ALLOWANCE.
   - 245 – THE SERVICE PROVIDED WAS GREATER THAN THAT USUALLY REQUIRED FOR THE LISTED PROCEDURE.
   - 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. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 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**

1. What is the recommended payment for the services in dispute?
2. Is additional reimbursement supported due to unusual circumstances (billed with modifier -22)?
3. Is the requestor entitled to additional reimbursement?

**Findings**

1. This dispute regards payment of medical services with reimbursement subject to the DWC *Medical Fee Guideline for Professional Services*, at 28 Texas Administrative Code §134.203, which requires that to determine the MAR (maximum allowable reimbursement), system participants shall apply Medicare payment policies with minimal modifications as set forth in the rule.

   Medicare assigns each service a relative value unit (RVU) for work, practice expense and malpractice. The RVUs are adjusted by provider geographic practice cost indexes (GPCI). The Medicare fee is the sum of these values multiplied by a conversion factor. The maximum allowable reimbursement (MAR) is calculated by substituting the DWC conversion factor. For surgery performed in a hospital, the division's 2017 conversion factor is $72.18.

   Reimbursement is calculated as follows:

   - Procedure code 23473-22 has a Work RVU of 25 multiplied by the Work GPCI of 1.02 is 25.5. The practice expense RVU of 17.07 multiplied by the PE GPCI of 1.009 is 17.22363. The malpractice RVU of 4.81 multiplied by the malpractice GPCI of 0.946 is 4.55026. The sum of 47.27389 is multiplied by the DWC conversion factor of $72.18 for a MAR of $3,412.23.
   - Procedure code 23473-80-22 (assistant surgeon services) has a Work RVU of 25 multiplied by the Work GPCI of 1.02 is 25.5. The practice expense RVU of 17.07 multiplied by the PE GPCI of 1.009 is 17.22363. The malpractice RVU of 4.81 multiplied by the malpractice GPCI of 0.946 is 4.55026. The sum is 47.27389 multiplied by the DWC conversion factor of $72.18 for a MAR of $3,412.23. The provider billed this code with modifier -80, indicating services performed by an assistant surgeon. When this modifier is supported, per Medicare payment policy (see *Medicare Claims Processing Manual*, Chapter 12 - Physicians/Nonphysician Practitioners, Section 20.4.3 - **Assistant-at Surgery-Services**) the fee schedule amount is 16% of the surgical payment, or $545.96.

2. The medical provider billed both services above with modifier -22, indicating unusual circumstances. Per Medicare payment policy (See *Medicare Claims Processing Manual* Chapter 12, Section 20.4.6 - **Payment Due to Unusual Circumstances**), at the carrier's discretion, payment may be increased or decreased based upon review of medical records and other documentation. Medicare does not assign a value for the services when modifier -22 is appended. Neither does Texas Medicaid or the division.

   The division's *Medical Fee Guideline for Professional Services,* Rule §134.203(f), requires that for products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid, or the division, reimbursement shall be provided in accordance with 28 Texas Administrative Code §134.1.

   Rule §134.1(e) requires that, in the absence of an applicable fee guideline or a negotiated contract, medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with a fair and reasonable reimbursement amount as specified in Rule §134.1(f).

   Rule §134.1(f) requires 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.

The Texas Supreme Court has summarized the statutory standards and criteria applicable to "fair and reasonable" fee determinations as requiring "methodologies that determine fair and reasonable medical fees, ensure quality medical care to injured workers, and achieve effective cost control." *Texas Workers' Compensation Commission v. Patient Advocates of Texas*, 136 *South Western Reporter Third* 643, 656 (Texas 2004). Additionally, the Third Court of Appeals has held, in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 *South Western Reporter Third* 96, 104 (Texas Appeals – Austin 2003, petition for review denied), that "[E]ach . . . reimbursement should be evaluated according to [Texas Labor Code] section 413.011(d)'s definition of 'fair and reasonable' fee guidelines as implemented by Rule 134.1 for case-by-case determinations."

Texas Labor Code §413.011(d) requires that:

> Fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commissioner shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines.

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) . . . 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 information presented by the requestor finds that, while the requestor maintains the services involved unusual circumstances, and that more effort may have been involved with the surgery and subsequent care, the requestor failed to provide sufficient information to support a specific additional payment amount for the value of the extra services provided.

It must further be noted the doctor states the procedure is more detailed and complex because "these patients have more severe deformity" due to "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 procedure; and "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." Yet review of the operative report finds no mention of severe deformity or morphological changes of the humerus or glenoid in this case. Neither did the surgeon note any difficulty identifying anatomical structures. Nor was any scar tissue documented in the record.

The surgeon asserts in the operative report that the reverse prosthesis requires more time for insertion, and states, "For this reason, I feel the use of a 22 modifier is indicated." However, no documentation was presented to establish the duration of this surgery. No start or stop times were found, nor any reference to a span of time. Moreover, no information was provided regarding the time required to perform a "typical unconstrained shoulder arthroplasty" version of this surgery, as a basis for comparison.

While candidates for the reverse shoulder prosthesis may in general present symptoms and complications supporting the unusual circumstances required for use of modifier -22, such symptoms or complications were not documented for this injured employee. The submitted medical records do not sufficiently support that unusual circumstances were present in this case.

Furthermore, the provider did not discuss or provide documentation to support that the additional payment sought was a fair and reasonable reimbursement for the extra services provided. Even were the rendered services supported as "over and above" the service level normally entailed, the provider did not demonstrate a specific value or method for calculating the extra payment required to achieve a fair and reasonable reimbursement.

The requestor did not discuss or support how the requested reimbursement was consistent with the criteria in Texas Labor Code §413.011, nor show how the requested payment ensures similar procedures provided in similar circumstances receive similar reimbursement; nor support that the requested payment was based on nationally recognized published studies, published division medical dispute decisions, or values assigned for services involving similar work and resource commitments Lastly, the requestor has not justified that the payment amount sought is a fair and reasonable rate of reimbursement. The requestor has not met the burden to support the additional payment request. Payment cannot be recommended.

3. The total amount allowed by the division's medical fee guideline is $3,958.19. Additional payment for unusual circumstances was not supported. The insurance carrier allowed $3,412.23 for the primary surgery and $545.96 for the assistant surgeon. The insurance carrier paid a total of $3,958.19 for the disputed services. The balance due is $0.00. No additional payment is recommended.

**Conclusion**

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons stated above, the division finds the requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

| | Grayson Richardson | July 20, 2018 |
|---|---|---|
| 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 Rule §133.307.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.