Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
FONDREN ORTHOPEDIC GROUP, LLP

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number
M4-18-3977-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
JUNE 13, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have received the EOB for put claim and we disagree with the payment amount we are asking there to be a consideration for additional payment in addition to the allowed amount. **The surgeon did bill with the 22 modifier to indicate that the services he had provided were a complexity and time procedure. The following code 23430/59 and 23333/59 payable w/59 modifiers for a distinct and separate service**."

Amount in Dispute: $3,538.58

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: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 21, 2017	CPT Code 23333-59-LT Surgeon Services for Removal of Foreign Body, Shoulder; Deep (Subfascial or Intramuscular)	$943.09	$0.00
	CPT Code 23430-59-LT Surgeon Services for Tenodesis of Long Tendon of Biceps	$1,558.44	$0.00
	CPT Code 23472-22-LT Surgeon Services for Arthroplasty, Glenohumeral Joint; Total Shoulder (Glenoid and Proximal Humeral Replacement (eg, Total Shoulder)	$763.92	$0.00
	CPT Code 23333-80-59-LT Assistant Surgeon Services for Removal of Foreign Body, Shoulder; Deep (Subfascial or Intramuscular)	$150.90	$0.00
	CPT Code 23472-80-22-LT Assistant Surgeon Services for Arthroplasty, Glenohumeral Joint; Total Shoulder (Glenoid and Proximal Humeral Replacement (eg, Total Shoulder)	$122.23	$0.00

TOTAL		$3,538.58	$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 medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets the reimbursement guidelines for professional service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 59-Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 4063-Reimbursement is based on the physician fee schedule when a professional service was performed I the facility setting.
   - 78-The allowance for this procedure was adjusted in accordance with multiple surgical procedure rules and/or guidelines.
   - 86-Service performed was distinct or independent from other services performed on the same day.
   - 5132-The billed service is considered inclusive the value of the primary service billed.
   - 245-The service provided was greater than that usually required for the listed procedure.
   - W3-Additional payment made on appeal/reconsideration.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 1115-We find the original review to be accurate and are unable to recommend any additional allowance.
   - 974-This procedure is included in the basic allowance of another procedure.
   - 5991-Payment is based on the assistant surgeon/minimal assistant fees per your state fee schedule or UCR for your zip code area.

Issues

1. What is the applicable fee guideline for professional services?
2. Is the allowance of CPT code 23333-59 and 23333-59-80 included in the allowance of another service/procedure rendered on the disputed date? Is the requestor entitled to reimbursement?
3. Is the allowance of CPT code 23430-59 included in the allowance of another service/procedure rendered on the disputed date? Is the requestor entitled to reimbursement?
4. Is the requestor entitled to additional reimbursement for codes 23472-22 and 23472-80?

Findings

1. The fee guidelines for disputed services is found at 28 Texas Administrative Code §134.203.
2. The respondent denied reimbursement for codes 23333-59 and 23333-59-80 based upon "97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated," and "974-This procedure is included in the basic allowance of another procedure."

   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 23020-LT, 23333-59-LT, 23430-59-LT, 23472-22-LT, 23020-80-LT, 23333-80-59-LT, 23430-80-59-LT and 23472-80-22-LT.

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

Per CCI edits, CPT code 23333 is a component of code 23472; however, a modifier is allowed to differentiate the service.

The requestor appended modifier 59-"Distinct Procedural Service" to code 23333 to differentiate it from 23472. Modifier "59" is defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

The requestor wrote in the Operative Report that both procedures were to claimant's left shoulder. The division finds the requestor did not support the use of modifier 59, specifically a "different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury." Therefore, the respondent's denial of payment is supported.

3. The respondent originally denied reimbursement for code 23430-59-LT based upon reason codes "97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated," and "974-This procedure is included in the basic allowance of another procedure." The respondent wrote that payment of $903.91 was being made for this code. The respondent did not submit any proof that payment was made. Because documentation to support this payment was not submitted, the division will review this code based upon original denial reasons.

   Per CCI edits, CPT code 23430-59-LT is a component of codes 23472; however, a modifier is allowed to differentiate the service.

   The requestor appended modifier 59-"Distinct Procedural Service" to code 23430 to differentiate it from 23472.

   The requestor wrote in the Operative Report that both procedures were to claimant's left shoulder. The division finds the requestor did not support the use of modifier 59, specifically a "different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury." Therefore, the respondent's denial of payment is supported.

4. The requestor billed $8,094.00 for code 23472-22-LT and $2,024.00 for 23472-80-22-LT. The respondent paid $3,055.68 for 23472-22-LT and $488.91 for 23472-80-22-LT based upon the fee guideline.

   The requestor contends that additional reimbursement is due for code 23472.

   The requestor appended modifier "22" to code 23472.

   Modifier "22-Increased Procedural Services" 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)."

   The division considered the following Medicare policies and guidelines:

   - The *Medicare Claims Processing Manual* Chapter 12 §20.4.6 entitled Billing Requirements for Global Surgeries *Payment Due to Unusual Circumstances (Modifiers "-22" and "-52")*, revision 1, 10-01-03, 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, A/B MACs (B) 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 titled *Billing Requirements for Global Surgeries,* Section (A) *Procedure Codes and Modifiers,* Subsection (10*), Unusual Circumstances* 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. Surgeries for which services performed are significantly less than usually required may be billed with the "-52" modifier. 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. There is no such restriction on the use of modifier "-52."

- 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. 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."

The division finds:

- The requestor provided an operative report required by *Medicare Claims Processing Manual* Chapter 12 §40.2.A.10.
- The requestor wrote in Operative Report, "The reverse prosthesis is a much more complex device than conventional shoulder arthroplasty requiring more time for insertion as well as more diligent followup to observe for the higher complication rate that can occur in the postoperative global period." This statement is not concise. The requestor is comparing this surgery to "conventional shoulder arthroplasty." This statement does not explain the unusual circumstances between this surgery and other surgeries billed with code 23472.
- The requestor's operative report does not meet the requirements of modifier 22 specifically it does not document the "increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required."

The division concludes the requestor did not support modifier -22.

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	08/22/2018 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.