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
TRUMBULL INSURANCE CO

MFDR Tracking Number
M4-19-0726-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
OCTOBER 10, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "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."

Amount in Dispute: $752.82

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Services were processed in accordance with Texas guidelines and fee schedule rate, Rule 134.203."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 28, 2018	CPT Code 29827-22	$570.69	$0.00
	CPT Code 29827-AS-22	$182.13	$0.00
TOTAL		$752.82	$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, effective May 31, 2012 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.

- 4063-Reimbursement is based on the physician fee schedule when a professional service was performed I the facility setting.
- 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.

Issues

1. What is the applicable fee guideline for professional services?
2. Is the requestor entitled to additional reimbursement for codes 29827-22 and 29827-AS-22?

Findings

1. The fee guidelines for disputed services is found at 28 Texas Administrative Code §134.203.
2. On the disputed date of service, the requestor billed CPT codes 29823-RT, 29826-RT, 29827-22-RT, 29823-AS-RT, 29826-AS-RT, and 29827-AS-22-RT. Only codes 29827-22 and 29827-AS-22 are in dispute.
3. The respondent paid $2,549.82 for codes 29827-22 and 29827-AS-22 based upon the fee guideline. The requestor is seeking additional reimbursement of $752.82.

   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."

   CPT code 29827 is described as "Arthroscopy, shoulder, surgical; with rotator cuff repair."

   The requestor appended modifier "22" and "AS" to code 29827.

   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)."

   Modifier "AS-Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery."

   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, "Modifier 22 was used because of the significant atrophy, fatty infiltration, and retraction mainly of the infraspinatus requiring significant releases in order to mobilize it and pull it laterally. Even then, it was very poor quality tissue, which required significant care and handling and placement of side-to-side sutures to assist with healing." This statement does not explain the unusual circumstances between this surgery compared to other surgeries billed with code 29827.
- 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	11/15/2018 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.