



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

FONDREN ORTHOPEDIC GROUP, LLP

**Respondent Name**

CITY OF HOUSTON

**MFDR Tracking Number**

M4-19-0060-01

**Carrier's Austin Representative**

Box Number 29

**MFDR Date Received**

SEPTEMBER 5, 2018

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "we are asking there to be a consideration for additional payment in addition to the allowed amount for the use of the 22 modifier (complex case)."

**Amount in Dispute:** \$3,514.47

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Based on the submitted documentation, the appropriate allowance was recommended per the Medicare Fee Guidelines and TX WC Fee Schedule. No further payment is recommended at this time."

**Response Submitted by:** Injury Management Organization, Inc.

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 5, 2018	CPT Code 63042-50 Laminectomy	\$943.09	\$0.00
	CPT Code 22633-22 Lumbar Arthrodesis	\$1,558.44	\$0.00
	CPT Code 22840-22 Instrumentation	\$763.92	\$0.00
TOTAL		\$3,514.47	\$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**

- 28 Texas Administrative Code §133.307, effective May 31, 2012 sets out the procedures for resolving a medical fee dispute.
- 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. 28 Texas Administrative Code §134.1, provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - P12-Workers' compensation jurisdictional fee schedule adjustment.
  - 300-The allowance has been made for a bilateral procedure.
  - 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we our original review to be correct. Therefore, no additional allowance appears to be warranted.
  - 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.

### **Issues**

1. Does the documentation submit support billing modifier 22?
2. Is the requestor entitled to additional reimbursement for code 22840-22?
3. Is the requestor entitled to additional reimbursement for codes 63042-50?

### **Findings**

1. The fee guidelines for disputed services is found at 28 Texas Administrative Code §134.203.

The requestor billed \$16,975.00 for CPT codes 63042-50, 22633-22 and 22840-22 rendered on February 5, 2018. The respondent paid \$7,672.12 for these services based upon the fee guideline. The requestor is seeking medical fee dispute resolution for an additional payment of \$3,514.47.

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 22830-59, 62350, 22853, 20931, 63044-59, 20936, 63044-59, 63042-50-59, 22633-22 and 22840-22.

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."

The requestor contends that additional reimbursement is due for code 22633 and 22840 because modifier 22 was appended because of the difficulty of procedure.

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,
  - This statement explains the unusual circumstances between this surgery and other surgeries billed with code 22840.
  - The requestor’s operative report does not explain the unusual circumstances between this surgery and other surgeries billed with code 22633.
  - The division concludes the requestor supported modifier -22 for code 22840 but not for 22633.
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 2018 DWC conversion factor for this service is 73.19.

The Medicare Conversion Factor is 35.9996

Review of Box 32 on the CMS-1500 the services were rendered in Houston, Texas; therefore, the locality will be based on “Houston, Texas”.

The Medicare participating amount for code 22840 in Houston, Texas is \$803.10.

Code 22840 is not subject to multiple procedure rule discounting.

Using the above formula, the MAR is \$1,632.77. The respondent paid \$1,632.77. The requestor is seeking additional reimbursement of \$415.13 for modifier 22.

As noted above, bills for surgeries with a “-22” modifier, are priced by individual consideration. For that reason, Medicare does not assign a relative value or payment fee schedule for modifier 22.

28 Texas Administrative Code §134.203(f) states “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).” Medicare does not assign a relative value or payment fee schedule for modifier 22; therefore, reimbursement is in accordance with §134.1.

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.”

Review of the submitted documentation finds that the requestor does not demonstrate or justify that the additional amount sought of \$415.13 for CPT code 22840-22 would be a fair and reasonable rate of reimbursement. As a result, additional reimbursement cannot be recommended.

- 3. The requestor is seeking additional reimbursement of \$2,092.13 for code 63042-50. The respondent paid \$2,077.98 based upon the fee guideline.

To determine if the requestor is due additional reimbursement the division refers to 28 Texas Administrative Code §134.203(c)(1)(2), and the above formula to calculate the MAR.

The division considered the following factors to determine the MAR:

- The Medicare participating amount for code 63042 in Houston, TX is \$1,355.74.
- This code is subject to multiple procedure discounting of 50%.
- The requestor appended modifier 50-bilateral procedure to code 63042; therefore, the MAR is 150%.

Using the above formula, the MAR is  $\$2,756.33 \times 150\% = \$4,134.49 \times 50\% = \$2,067.24$ . The respondent paid \$2,077.98. As a result, additional reimbursement is not 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**

\_\_\_\_\_  
Signature

Elizabeth Pickle, RHIA  
Medical Fee Dispute Resolution Officer

02/12/2019  
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.**