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
HARTFORD CASUALTY INSURANCE CO

MFDR Tracking Number
M4-19-2626-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
JANUARY 14, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Due to the complexity and time involved, we are asking that this claim be reviewed for additional payment."

Amount in Dispute: $396.59

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Services processed correctly in accordance with Rule 134.203. No additional reimbursement is recommended for modifier 22."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 19, 2018	CPT Code 25607-22 Upper Extremity Surgery	$396.59	$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. 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.
   - 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.

Issues

Does the documentation submit support billing modifier 22? Is the requestor entitled to additional reimbursement for code 25607-22?

Findings

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

   The requestor billed $2,019.00 for CPT code 25607-22 rendered on July 19, 2018. The respondent paid $1,559.86 for these services based upon the fee guideline. The requestor is seeking medical fee dispute resolution for an additional payment of $396.59.

   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 25260-RT, 25290-59-RT, 29847-22 and 25607-22.

   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."

   CPT code 25607 is described as "Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation."

   The requestor contends that additional reimbursement is due for code 25607 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 supports the surgery was complicated, but does not document "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)" compared to other surgeries billed with code 25607.
- The division concludes the requestor did not support billing modifier -22 for code 25607. The request for additional reimbursement is not supported.

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	02/14/2019 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.