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
CITY OF HOUSTON

MFDR Tracking Number
M4-19-2767-01

Carrier's Austin Representative
Box Number 29

MFDR Date Received
JANUARY 18, 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: $190.84

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the submitted documentation no additional allowance is warranted. The bill was processed and paid per the Fee Schedule for the CPT codes submitted."

Response Submitted by: Injury Management Organization

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 8, 2018	CPT Code 22633-AS-22 Lumbar Surgery	$135.14	$0.00
	CPT Code 22840-AS-22 Lumbar Surgery	$55.70	$0.00
TOTAL		$190.84	$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

1. Does the documentation submit support billing modifier 22?
2. Is the requestor entitled to additional reimbursement for codes 22633-AS-22 and 22840-AS-22?

Findings

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

   The requestor is seeking dispute resolution for CPT codes 22633 and 22840 in the amount of $190.84. The respondent contends that "Based on the submitted documentation no additional allowance is warranted. The bill was processed and paid per the Fee Schedule for the CPT codes submitted."

   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 63042-AS-50-59, 22830-AS-59, 62350-AS, 22853-AS, 63044-AS-59, 63044-AS-59, 22633-AS-22, and 22840-AS-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 22633 is described as "Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar."

   CPT code 22840 is described as "Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)."

   The requestor contends that additional reimbursement is due for codes 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.
- This statement supports the surgery was complicated and documents additional time and reason for the additional work.
- The division concludes the requestor supports billing modifier -22 for code 22633 and 22840.

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 requestor billed with modifier "AS" for physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery.

Medicare Claims Processing Manual, Chapter 12, Section 120.1 titled Limitations for Assistant-at-Surgery Services Furnished by Nurse Practitioners and Clinical Nurse Specialists (Rev. 2656, Issuance: 02-07-13, Effective: 02-19-13, Implementation: 02-19-13) states, "Medicare law at section 1833(a)(1)(O) of the Social Security Act authorizes payment for services that NPs and CNSs furnish as an assistant-at-surgery. Specifically, when a NP or CNS actively assists a physician in performing a surgical procedure and furnishes more than just ancillary services, the NP's and CNSs' services are eligible for payment as assistant-at-surgery services… The A/B MAC (B) shall pay covered NP and CNS assistant-at-surgery services at 80 percent of the lesser of the actual charge or 85 percent of the 16 percent that a physician is paid under the Medicare Physician Fee Schedule. Since physicians are paid at 16 percent of the surgical payment amount under the Medicare Physician Fee Schedule for assistant-at-surgery services, the actual payment amount that NPs and CNSs receive for assistant-at-surgery services is 13.6 percent of the amount paid to physicians. Only the AS modifier must be reported on the claim form when a NP or CNS bills assistant-at-surgery services"

Using the above formula, the division finds:

Code	Medicare Participating Amount	MAR is 85% of 16% of payment for physician	Carrier Paid
22633	$1,948.46	$538.73	$538.75
22840	$803.10	$222.05	$222.06

The requestor is seeking additional reimbursement of $190.84 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 $135.14 for CPT codes 22633-AS-22 and $55.70 for 22840-AS-22 would be a fair and reasonable rate of reimbursement. As a result, additional reimbursement cannot be 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	Medical Fee Dispute Resolution Officer	03/21/2019 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.