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
FARMINGTON CASUALTY CO

MFDR Tracking Number
M4-19-2867-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
JANUARY 23, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are writing in regards to the denial of procedure 63044/AS (Laminotomy with partial facetectomy and foraminotomy, bilateral L3-L4 as lacking information and invalid procedure code. We find that the charge of 63044/AS is a valid, compensable as separate charges and a copy of supporting documentation is attached."

Amount in Dispute: $273.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider contends they are entitled to additional reimbursement for CPT code 22633 (arthrodesis). The Carrier has reviewed the documentation and determined the Provider was properly reimbursed under the Medicare cascading reduction for multiple procedures. The Provider is not entitled to additional reimbursement for the disputed services. The Provider further contends they are entitled to reimbursement for CPT code 63044 (laminotomy at additional levels). The Carrier has reviewed the documentation and determined the Provider was properly reimbursed. There is no Maximum Allowable Reimbursement as determined under the Division's fee schedule for this procedure code. The Provider is not entitled to additional reimbursement for the disputed services."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 23, 2018	CPT Code 22633-80-22	$135.14	$0.00
	Cpt Code 63044-80-50-59	$138.56	$0.00
TOTAL		$273.70	$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:
   - W3-Additional payment made on appeal/reconsideration.
   - 181-Payment adjusted because this procedure code was invalid on the date of service.
   - 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.
   - 254-The billed service has no allowance in fee schedule.
   - 531-Please re-submit with the appropriate HCPCS/CPT Code.

Issues

Is the requestor entitled to additional reimbursement for code 22633-80-22 and 63044-80-50-59?

Findings

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

   On the disputed date of service, the requestor billed CPT codes 22633-80-22, 63042-80-50-59, 63047-80-59, 22842-80, 22632-80, 22853-80, 22853-80-76, and 63044-80-50-59. Only codes 22633-80-22 and 63044-80-50-59 are in dispute.

   The respondent paid $538.75 for code 22633-80-22 based upon the fee guideline. The requestor is seeking additional reimbursement of $135.14.

   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 22633-80-22 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."

   The requestor appended modifiers "80- Assistant Surgeon" and "Modifier "22-Increased Procedural Services" to code 22633.

   The *Medicare Claims Processing Manual* Chapter 12 §20.4.3 entitled *Assistant at Surgery Services* effective February 19, 2013, states "For assistant-at-surgery services performed by physicians, the fee schedule amount equals 16 percent of the amount otherwise applicable for the surgical payment."

   The requestor contends that additional reimbursement is due for code 22633 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, “I would estimate that the interbody fusions took about twice as long as in a patient without a previous lumbar surgery. The patient’s body habitus was also prohibitive. He has a body mass index of 38.1 again prolonging the time to perform the interbody fusion.”
- This statement supports the unusual circumstances between this surgery and other surgeries billed with codes 22633.
- The division concludes the requestor supported modifier -22 for code 22633.

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 22633-80-22 in Houston, Texas is $1,948.46.

Code 22633 is subject to multiple procedure rule (MPR) discounting of 50% of MAR.

Using the above formula, the MAR is $3,102.31 X 50% for MPR = $1,980.69. Because the requestor billed with modifier 80 for assistant at surgery services, this amount is multiplied by 16% = $316.91 The respondent paid $538.75.

The requestor is seeking additional reimbursement of $135.14 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 22633-80-22 would be a fair and reasonable rate of reimbursement. As a result, additional reimbursement cannot be recommended.

2. The requestor billed $915.00 for code 63044-80-50-59. The respondent paid $0.00 based upon "531-Please re-submit with the appropriate HCPCS/CPT Code." The requestor is seeking dispute resolution for reimbursement of $138.56.

   CPT code 63044 is described as "Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace (List separately in addition to code for primary procedure)."

   The requestor appended modifiers, "80- Assistant Surgeon", "50-Bilateral Surgery", and "59-Distinct Separate Service" to code 63044.

   Medicare does not assign a relative value or payment fee schedule for CPT code 63044.

   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)."

   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 reimbursement amount sought of $138.56 for CPT code 63044-80-50-59 would be a fair and reasonable rate of reimbursement. As a result, 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	2/15/2019 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.