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
TEXAS BACK INSTITUTE

Respondent Name
GENERAL MOTORS LLC

MFDR Tracking Number
M4-19-3937-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
APRIL 26, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have appealed the denial for the above patient for procedure codes 22830; 22830.80; 63048.22. The patient had a Posterior Lumbar Interbody Fusion performed by Dr. Michael Duffy. The carrier states procedure code 22830 and 22830.80 were included in another procedure performed on that day. According to the 2019 CPT manual, this procedure is for the exploration of spinal fusion and is not included in any of the procedures that were billed on this day. Procedure code 63048.22 was billed for 2 units. The carrier paid for one for the surgeon and paid both units for the assistant surgeon."

Amount in Dispute: $3,902.49

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Texas Back Institute has failed to provide any sufficient reasoning why it is entitled to additional reimbursement, or how the limited documentation submitted justifies additional payment. As reflected in the attached explanation of benefits (EOBs), General Motors has properly reimbursed Texas Back Institute in accordance with the Texas Workers' Compensation Act and Medical Fee Guidelines."

Response Submitted by: Burns Anderson Jury & Brenner, LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 31, 2018	CPT Code 22830	$2,749.36	$0.00
	CPT Code 22830-80	$439.90	$0.00
	CPT Code 63048-22	$713.23	$0.00
TOTAL		$3,902.49	$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:
   - 59-Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 5205-Cannot review bill without medical notes for date(s) of service. Please submit medical notes with the bill to expedite processing.
   - 226-Information requested from the billing/rendering provider was not provided or not provided timely or was insufficient/incomplete.
   - 948-Re-reviewed at providers request with additional information and documentation additional payment suggested.
   - 247-A payment or denial has already been recommended for this service.
   - 18-Exaxt duplicate claim/service.
   - 78-The allowance for this procedure was adjusted in accordance with multiple surgical procedure rules and/or guidelines.
   - 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.
   - 97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - OA-The amount adjusted is due to bundling or unbundling of services.
   - 899-In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient code editor) component codes of comprehensive surgery: Musculoskeletal system procedure (20000-29999) has been disallowed.
   - 4480-Recommended allowance has been authorized by the payor.
   - 4063-Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting.

Issues

1. Is the allowance of CPT codes 22830 and 22830-80 included in the allowance of another service/procedure rendered on the disputed date? Is the requestor entitled to reimbursement?
2. Is the requestor entitled to additional reimbursement for code 63048-22?

Findings

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

2. The requestor is seeking medical fee dispute resolution for the surgeon and assistant surgeon services for code 22830.

   The respondent denied reimbursement for codes 22830 and 22830-80 based upon "97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated," "OA-The amount adjusted is due to bundling or unbundling of services," and "899-In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient code editor) component codes of comprehensive surgery: Musculoskeletal system procedure (20000-29999) has been disallowed."

   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 22612, 63047, 22830, 22842, 22614, 63048, 20936 and 20930.

   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."

Per CCI edits, CPT code 22830 is a component of code 22612; however, a modifier is allowed to differentiate the service.

The requestor appended modifier "80- Assistant Surgeon" to code 22830. This modifier does not differentiate the service from code 22612. The respondent's denial of payment is supported for code 22830 and 22830-80.

3. The respondent paid $429.20 for CPT code 63048-22 based upon the fee guideline.

   The requestor contends that additional reimbursement is due for code 63048.

   The requestor appended modifier "22" to code 63048.

   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 did not explain in Operative Report the unusual circumstances between this surgery and other surgeries billed with code 63048.
   - 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

		10/10/2019
Signature	Medical Fee Dispute Resolution Officer	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.