



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

Trinity Orthopedics

Respondent Name

Indemnity Insurance Company of North America

MFDR Tracking Number

M4-15-0595-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

October 14, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "[The] medical bill dated July 22, 2013 in the total amount of \$1086.00 has been processed and CPT 99203 has denied several times stating the charge was mad for a visit on the same day as a surgical procedure, or within the 90 day follow up period of a previously performed surgery. This claim has been denied twice with the EOBs attached for your review. This was a new patient evaluation which needed to be completed in order for the doctor to proceed into treating the patient. The appropriate modifiers are attached to the line item. Please review the attached letters of Reconsideration submitted to the insurance company. Trinity Orthopedics has extensive documentation attached which supports the billing.

Trinity Orthopedics has exhausted their efforts to have the bill pay correctly by the insurance company and is now seeking the intervention of TDI."

Amount in Dispute: \$210.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor submitted a charge for an office visit using the modifier -25 alleging the Claimant's condition required a significant, separately identifiable E/M service. However, the documentation does not reflect that a separate identifiable service was performed above and beyond the CPT code 28400, treatment for the closed calcaneal fracture.

In conclusion, no reimbursement should we awarded for the office visit as it was inclusive in CPT code 28400."

Response Submitted by: Downs-Stafford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 22, 2014	New Patient Evaluation/Management (99203)	\$210.00	\$166.00

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 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.203 provides the fee guidelines for billing and reimbursing professional medical bills.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - F090 – Rendering providers state license Qualifier is missing or invalid. Please resubmit bill with this information included.
 - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
 - 59 – Processed based on multiple or concurrent procedure rules.
 - U034 – A charge was made for a visit on the same day as a surgical procedure, or within the 90 day follow up period of a previously performed surgery.
 - ZD86 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Did the requestor support that the disputed CPT code 99203 is separately payable according to 28 Texas Administrative Code §134.203?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, “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; ... and other payment policies in effect on the date a service is provided...”
 Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of a new patient. At this appointment, the doctor decided to perform a radiological examination and the surgical procedure – closed treatment of fracture of calcaneus without manipulation – which were both performed and billed on the same day.
 The insurance carrier denied the disputed charges stating, “Processed based on multiple or concurrent procedure rules.” Review of the correct coding initiative (CCI) edits finds that none of the codes billed were in conflict. The documentation submitted does not support a denial based on multiple procedure rules.
 The insurance carrier also denied the disputed charges stating, “A charge was made for a visit on the same day as a surgical procedure, or within the 90 day follow up period of a previously performed surgery.” Review of CPT code 28400 finds that the procedure does have a 90-day global period. Medicare policy indicates that a 90-day global period is for major procedures and includes one day pre-operative evaluation, an evaluation the day of the procedure is generally not payable as a separate service, and the total global period is 92 days (including the day before and day of the surgery).
 Review of the submitted documentation finds that the requestor billed the evaluation and management code with modifiers 57 and 25. Modifier 57 is defined as “An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.” Medicare policy states that an evaluation and management service may be separately payable if it resulted in the initial decision to perform a **major surgery**. Because the accompanying surgery has a 90-day global period, it qualifies as a major surgery as defined above. The submitted documentation supports that the disputed evaluation and management service resulted in the initial decision to perform the accompanying surgery. Therefore, the requestor has supported that the disputed CPT code 99203 is separately payable according to 28 Texas Administrative Code §134.203.
2. Procedure code 99203, service date July 22, 2014, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 1.42 multiplied by the geographic practice cost index (GPCI) for work of 1.002 is 1.42284. The practice expense (PE) RVU of 1.47 multiplied by the PE GPCI of 0.987 is 1.45089. The malpractice RVU of 0.13 multiplied by the malpractice GPCI of 0.799 is 0.10387. The sum of 2.9776 is multiplied by the Division conversion factor of \$55.75 for a MAR of \$166.00.
 The total allowable reimbursement for the services in dispute is \$166.00. The insurance carrier paid \$0.00. Therefore, the requestor is entitled to an additional reimbursement of \$166.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$166.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$166.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	February 6, 2015
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.