



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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

DR. DAVID P. LONCARICH

Respondent Name

LM INSURANCE CORP

MFDR Tracking Number

M4-16-1695-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

FEBRUARY 19, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We respectfully disagree with this denial on code 99213/24 as being a duplicate claim, when in fact a modifier 24 was added to the code."

Amount in Dispute: \$115.87

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The professional visit charges of 6/22/2015 were denied as included in the global surgical follow up for the surgical procedure of May 11, 2015. The provider included a copy of the report for that date in the request documentation. We are including with our response a copy of the payment EOB for that date of service as well as a copy of a CMS publication on this subject."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: June 22, 2015, CPT Code 99213-24 Office Visit, \$115.87, \$115.87

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 §133.20, effective January 29, 2009 sets out the health care providers billing procedures.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- 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.

- U301-This item has been reviewed on a previously submitted bill, or is currently in process. Notification of decision has been previously provided or will be issued upon completion of our review.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3-Additional payment made on appeal/reconsideration.
- X598-Claim has been re-evaluated based on additional documentation submitted; no additional payment due.

Issues

1. The issue in dispute is whether or not the June 22, 2015 office visit (CPT code 99213) is included in the global surgery package of code 20694 rendered on May 11, 2015?
2. Is the requestor entitled to reimbursement for CPT code 99213?

Findings

1. The insurance carrier denied reimbursement for the office visit , CPT code 99213, based upon reason codes “U034,” and “U301.” The respondent contends that reimbursement is not due because “The professional visit charges of 6/22/2015 were denied as included in the global surgical follow up for the surgical procedure of May 11, 2015.” In support of their position, the respondent submitted a copy of explanation of benefits that indicate that the requestor billed CPT codes 20694-LT and 11044-LT on May 11, 2015.

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.”

A review of the submitted documentation finds:

DATE	CODE	DESCRIPTION	GLOBAL DAYS	Principal Diagnosis Code
May 11, 2015	11044	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less	000	823.90
May 11, 2015	20694	Removal, under anesthesia, of external fixation system	90	823.90
June 22, 2015	99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low		736.72

		<p>complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.</p>		
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Per Medicare Claims Processing Manual, Chapter 12, (40.2)(A), Billing Requirements for Global Surgery section (1) titled Physicians Who Furnish the Entire Global Surgical Package states:

Physicians who perform the surgery and furnish all of the usual pre-and postoperative work bill for the global package by entering the appropriate CPT code for the surgical procedure only. Billing is not allowed for visits or other services that are included in the global package.

Per the submitted medical reports, Dr. Mark R. Brinker performed the surgery and Dr. David P. Loncarich performed the disputed evaluation and management service. The disputed office visit was performed within the 90 day global surgery package for code 20694.

Per Medicare Claims Processing Manual, Chapter 12, (40.2)(B), Billing Requirements for Global Surgery, section (2) titled Services Not Included in the Global Surgical Package states:

Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery

A review of the submitted documentation finds that the May 11, 2015 surgery was performed on the claimant's left Tibia and the disputed office visit was for evaluation of the left ankle; therefore, the evaluation was for a unrelated diagnosis.

Per Medicare Claims Processing Manual, Chapter 12, (40.2)(A)(7), Billing Requirements for Global Surgery, Unrelated Procedures or Visits During the Postoperative Period :

Two CPT modifiers were established to simplify billing for visits and other procedures which are furnished during the postoperative period of a surgical procedure, but which are not included in the payment for the surgical procedure

Modifier “-24”: Reports an unrelated evaluation and management service by same physician during a postoperative period. The physician may need to indicate that an evaluation and management service was performed during the postoperative period of an unrelated procedure. This circumstance is reported by adding the modifier “-24” to the appropriate level of evaluation and management service.

Services submitted with the “-24” modifier must be sufficiently documented to establish that the visit was unrelated to the surgery. A diagnosis code that clearly indicates that the reason for the encounter was unrelated to the surgery is acceptable documentation.

A review of the submitted medical billing finds that the requestor appended modifier “24” to CPT code 99213 to indicate that the service was unrelated to codes 20694 in accordance with *Medicare Claims Processing Manual, Chapter 12, (40.2)(A)(7)*. Therefore, the Division finds that the disputed office visit is not global to code 20694. As a result, reimbursement is recommended.

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 2015 DWC conversion factor for this service is 56.2.

The Medicare Conversion Factor is 35.7547

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77030, which is located in Houston, Texas; therefore, the Medicare participating amount is based on locality “Houston, Texas”.

The Medicare participating amount for code 99213 is \$73.72.

Using the above formula, the MAR is \$115.87; this amount is recommended for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$115.87.

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 \$115.87 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	03/23/2016
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, 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 MFDR 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.