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
CLINICS OF NORTH TEXAS

Respondent Name
FIRST LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-19-2701-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
JANUARY 15, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The original claim was denied due to the charge was made for a visit on the same day as a surgical procedure, or within the 90 day global period. The surgery was done by Dr. Langer who is a surgeon and the visit we are trying to get paid is for Dr. Wolinksi. These are 2 different doctors with 2 different specialties. I have included all documentation that we have to support this."

Amount in Dispute: $159.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill has been reviewed as denial stands as patient had surgical procedure on 1/25/18 with DX K4090 unilateral inguinal hernia, without obstruction or gangrene, not specified as recurrent. He returned to the office on 2/1/18 and saw a different provider in the practice and was seen with the same DX. Per the notes submitted for DOS 2/1/18, that patient 'presents for a recheck of inguinal hernia.' Per encoder PRO, the surgical procedure has 90 day global period. Copy of that information is submitted for your review."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 1, 2018	CPT Code 99213 Office Visit	$159.00	$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 the reimbursement guidelines for the disputed service.
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.
   - 48-The provider billed for a visit on the same day of surgery or within the follow-up of a previously performed surgery.
   - W3-Additional payment made on appeal/reconsideration.
   - 236-This proc or proc/mod combo not compatible w/another proc on same day.
   - W3-Appeal/reconsideration.

Issues

The issue in dispute is whether the February 1, 2018 office visit (CPT code 99213) is included in the global surgery package of CPT code 49505 rendered on January 25, 2018

Findings

1. The requestor is seeking reimbursement of $159.00 for CPT code 99213.

2. The fee guideline for Professional Care services is found in 28 Texas Administrative Code §134.203.

3. The insurance carrier denied reimbursement for the office visit , CPT code 99213, based upon reason code s "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," and "48-The provider billed for a visit on the same day of surgery or within the follow-up of a previously performed surgery."

4. The respondent wrote "The bill has been reviewed as denial stands as patient had surgical procedure on 1/25/18 with DX K4090 unilateral inguinal hernia, without obstruction or gangrene, not specified as recurrent. He returned to the office on 2/1/18 and saw a different provider in the practice and was seen with the same DX. Per the notes submitted for DOS 2/1/18, that patient 'presents for a recheck of inguinal hernia.' Per encoder PRO, the surgical procedure has 90 day global period."

5. 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."

   Per Medicare Claims Processing Manual, Chapter 12, (40.2)(A)(1)(2), Billing Requirements for Global Surgery:

   > To ensure the proper identification of services that are, or are not, included in the global package, the following procedures apply.
   >
   > **A. Procedure Codes and Modifiers**
   >
   > Use of the modifiers in this section apply to both major procedures with a 90-day postoperative period and minor procedures with a 10-day postoperative period (and/or a zero day postoperative period in the case of modifiers "-22" and "-25").

1. Physicians Who Furnish the Entire Global Surgical Package

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.

2. Physicians in Group Practice

When different physicians in a group practice participate in the care of the patient, the group bills for the entire global package if the physicians reassign benefits to the group. The physician who performs the surgery is shown as the performing physician. (For dates of service prior to January 1, 1994, however, where a new physician furnishes the entire postoperative care, the group billed for the surgical care and the postoperative care as separate line items with the appropriate modifiers.)

Medicare Claims Processing Manual, Chapter 12, (40.2)(A)(7), Billing Requirements for Global Surgery states:

7. 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 "-79": Reports an unrelated procedure by the same physician during a postoperative period. The physician may need to indicate that the performance of a procedure or service during a postoperative period was unrelated to the original procedure.

A new postoperative period begins when the unrelated procedure is billed.

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 physician who is responsible for postoperative care and has reported and been paid using modifier "-55" also uses modifier "-24" to report any unrelated visits.

6. The issue in dispute is whether or not the February 1, 2018 office visit (CPT code 99213) is included in the global surgery package of CPT code 49505 rendered on January 25, 2018.

7. CPT code 49505 is defined as "Repair initial inguinal hernia, age 5 years or older, reducible " and has a 90-day global surgery postoperative period.

8. The requestor wrote, "The surgery was done by Dr. Langer who is a surgeon and the visit we are trying to get paid is for Dr. Wolinksi. These are 2 different doctors with 2 different specialties."

9. A review of the submitted documentation finds:

- Claimant underwent surgery, CPT code 49505, on January 25, 2018.
- CPT code 49505 has a 90 day global surgery postoperative period.
- The disputed office visit was rendered on February 1, 2018.
- The disputed office visit falls within the global surgery postoperative period for CPT code 49505 rendered on January 25. 2018.
- Dr. Langer performed the surgery and Dr. Wolinski performed the follow-up visit.
- Both physicians Dr. Langer and Dr. Wolinski are part of the same group practice.
- The requestor argues that reimbursement is due because Dr. Langer is different specialty than Dr. Wolinski.
- Per Medicare policy regarding group practice, "When different physicians in a group practice

participate in the care of the patient, the group bills for the entire global package if the physicians reassign benefits to the group. The physician who performs the surgery is shown as the performing physician." The requestor did not submit documentation to support separate reimbursement from group practice was due to Dr. Wolinski.

- The disputed office visit is for "Recheck of Inguinal hernia."
- This diagnosis is related to the January 25, 2018 surgery.
- The Medicare policy on post-operative global fee surgical package applies to the service in dispute.
- The requestor did not append any modifiers to CPT code 99213 to indicate that it was an unrelated to code 49505 in accordance with *Medicare Claims Processing Manual, Chapter 12, (40.2)(A)(7)*.
- The disputed office visit is global to code 49505. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that 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	02/28/2019 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.