Texas Department of Insurance
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TERESA GODINEZ, MD

Respondent Name
FEDERAL INSURANCE CO

MFDR Tracking Number
M4-19-3347-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
MARCH 4, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We do not perform surgeries – we are an Urgent Care facility. Follow up visits DOS 5/16/18, 5/21/18, 5/25/18 + 6/04/18 should have paid as well."

Amount in Dispute: $741.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Review of CPT code 28510 performed on 05/07/18 by Teresa Godinez, MD (Exhibit B) finds that the procedure has a 90-day global period (Exhibit C)…E&M services related to recovery from the surgical procedure during the postoperative period are included in the global surgical package as are E&M services related to complications of the surgery…CorVel respectfully notes the requestor did not bill with an appropriate modifier per NCCI policy to indicate that it qualified as a separately reportable service or an unrelated evaluation during the postoperative period."

Response Submitted By: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 16, 2018 May 21, 2018 May 25, 2018	CPT Code 99214 Office Visit	$195.14	$0.00
May 16, 2018 May 21, 2018 May 25, 2018 June 4, 2018	CPT Code 99080-73 Work Status Report	$0.00	$0.00
June 4, 2018	CPT Code 99213 Office Visit	$156.00	$0.00
TOTAL		$741.92	$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 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.239, effective July 7, 2016, sets out medical fee guidelines for workers' compensation specific services.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
4. 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - R13-Visit falls within a surgery follow-up period.
    - 97-Charge included in another charge or service.
    - 97A-Provider appeal.
    - B20-Srvc partially/fully furnished by another provider.

Issues

Does the Medicare policy on post-operative global fee periods apply to the service in dispute?

Findings

1. The fee guidelines for disputed services are found in 28 Texas Administrative Code §134.203.
2. The insurance carrier denied reimbursement for the office visit , CPT code 99214, based upon reason codes "97-Charge included in another charge or service," and "R13-Visit falls within a surgery follow-up period." CPT code 99213 was denied based upon "B20-Srvc partially/fully furnished by another provider."
3. 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."
4. The office visits are described as:

    CPT code 99214 - "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or 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 moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family."

    CPT code 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 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."

5. The issue in dispute is whether or not the disputed office visits (CPT codes 99214 and 99213) are included in the global surgery package of CPT code 28510 performed on May 7, 2018.

6. CPT code 28510 is described as "Closed treatment of fracture, phalanx or phalanges, other than great toe; without manipulation, each " and has a 90-day global days postoperative period.

7. A review of the submitted documentation finds that the requestor performed the surgery and post-operative office visits. Therefore, the Division finds that the Medicare policy on post-operative global fee surgical package applies to the service in dispute.

8. *Per Medicare Claims Processing Manual, Chapter 12, (40.2)(A)(1), 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.

9. *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.

   A review of the submitted medical billing finds that the requestor did not append a modifier to CPT code 99214 or 99213 to indicate that the service was unrelated to code 28510 in accordance with *Medicare Claims Processing Manual, Chapter 12, (40.2)(A)(7).* Therefore, the Division finds that the disputed office visits are global to code 28510. 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	4/11/2019 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.