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
SHANNON CLINIC

Respondent Name
SERVICE LLOYDS INSURANCE CO

MFDR Tracking Number
M4-19-4623-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
JUNE 24, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please review and consider for payment."

Amount in Dispute: $140.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We find that no other modifier billed to distinguish separate payment outside of the global procedure of DOS 10/11/18 service 29848 performed by Dr Haley that has a 90 day follow up period thus DOS 1/9/19 for E&M 99213 with Dr. Richie is denied as globe."

Response Submitted By: Avidel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 9, 2019	CPT Code 99213 Office Visit	$140.00	$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 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:

- 282-The insurance company is reducing or denying payment after reconsidering a bill.
- 350-Bill has been identified as a request for reconsideration or appeal.
- P12-Workers' compensation jurisdictional fee schedule adjustment.
- W3-In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 375-No additional allowance guidelines indicate that an E&M service provided on the day of surgery or within preoperative period or during postoperative follow up period is not eligible for separate reimbursement from the physician or physician group practice.

Issues

Is the requestor entitled to reimbursement for office visit rendered on January 9, 2019?

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 99213, based upon reason code "375-No additional allowance guidelines indicate that an E&M service provided on the day of surgery or within preoperative period or during postoperative follow up period is not eligible for separate reimbursement from the physician or physician group practice."
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. CPT code 99213 is described as "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 visit (CPT code 99213) is included in the global surgery package of CPT code 29848 performed on January 9, 2019.

6. CPT code 29848 is described as "Endoscopy, wrist, surgical, with release of transverse carpal ligament " and has a 90-day global postoperative period.

   A review of the submitted documentation finds that the office visit was performed on the 90th day after the surgery. Therefore, the Division finds that the Medicare policy on post-operative global fee surgical package applies to the service in dispute.

7. *Per Medicare Claims Processing Manual, Chapter 12, (40.2)(A)(2)(3), 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")

   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.)

3. Physicians Who Furnish Part of a Global Surgical Package

Where physicians agree on the transfer of care during the global period, the following modifiers are used:

- "-54" for surgical care only; or
- "-55" for postoperative management only.

Both the bill for the surgical care only and the bill for the postoperative care only, will contain the same date of service and the same surgical procedure code, with the services distinguished by the use of the appropriate modifier.

Providers need not specify on the claim that care has been transferred. However, the date on which care was relinquished or assumed, as applicable, must be shown on the claim. This should be indicated in the remarks field/free text segment on the claim form/format. Both the surgeon and the physician providing the postoperative care must keep a copy of the written transfer agreement in the beneficiary's medical record.

The submitted documentation does not indicate if the provider and the surgeon are/are not from the same group practice; if the claimant is being transferred to the requestor for postoperative management care; and the requestor did not append any modifiers to clarify the billing of an evaluation and management service during the global period.

8. *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 99213 to indicate that the service was unrelated to code 29848 in accordance with *Medicare Claims Processing Manual, Chapter 12, (40.2)(A)(7).* Therefore, the Division finds that the requestor did not support payment is due for the disputed office visit. 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

		7/11/2019
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.