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
JAY C. PROCTOR, MD

Respondent Name
SERVICE LLOYDS INSURANCE CO

MFDR Tracking Number
M4-15-2369-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
MARCH 31, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Denied Pmt of Xray of finger. This Xray was done at our facility we bill Radiologist for service. Please pay for Xray."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "1. CorVel will maintain the requestor, Jay Clifford Proctor III, MD is entitled to $0.00 reimbursement for date of service 07/18/14, CPT Code 99213 in the amount of $100.00 based on the global surgical package associated with a surgical procedure performed in the physician's office on 07/14/14. Per Medicare CPT Code 12021 has a total global period of 11 days, with 10-days indicated as the post-operative period inclusive to the original surgical procedure. Therefore, separate payment would not be allowed for the office visit 4-days post-operatively.

2. CorVel will maintain the requestor, Jay Clifford Proctor III, MD is entitled to $0.00 reimbursement for date of service 09/30/14, CPT Code 73140 in the amount of $50.00 based on failure to accurately submit medical billing data in accordance with division rules set forth for a licensed provider."

Response Submitted by: Corvel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 18, 2014	CPT Code 99213 Office Visit	$100.00	$0.00
September 30, 2014	CPT Code 73140 X-rays of Finger (minimum 2 views)	$50.00	$0.00
TOTAL		$150.00	$0.00

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:
   - R13-Visit falls within a surgery follow-up period.
   - 236-This proc or proc/mod combo not compatible w/another proc on same day.
   - W3-Appeal/reconsideration.
   - B20-Srvc partially/fully furnished by another provider.
   - Per Rule 133.20(e)(2) a medical bill must be submitted in the name of the licensed HCP that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care.

Issues

1. Does the Medicare policy on post-operative global fee periods apply to the service in dispute?
2. Was the disputed X-ray billed in accordance with 28 Texas Administrative Code §133.20?

Findings

1. The insurance carrier denied reimbursement for the office visit , CPT code 99213, based upon reason code "R13". The respondent contends that reimbursement is not due because "based on the global surgical package associated with a surgical procedure performed in the physician's office on 07/14/14. Per Medicare CPT Code 12021 has a total global period of 11 days, with 10-days indicated as the post-operative period inclusive to the original surgical procedure. Therefore, separate payment would not be allowed for the office visit 4-days post-operatively." In support of their position, the respondent submitted a copy of the July 14, 2014 explanation of benefits that indicate that the requestor billed CPT codes 12021, 99203, 90715, 73140, 90471, and 99080.

   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), 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.

   The issue in dispute is whether or not the July 18, 2014 office visit (CPT code 99213) is included in the global surgery package of CPT code 12021 rendered on July 14, 2014.

CPT code 12021 is defined as "Treatment of superficial wound dehiscence; with packing " and has a 10-day postoperative period.

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

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 12021 in accordance with *Medicare Claims Processing Manual, Chapter 12, (40.2)(A)(7).* Therefore, the Division finds that the disputed office visit is global to code 12021. As a result, reimbursement is not recommended.

2. According to the explanation of benefits, the respondent denied reimbursement for CPT code 73140 based upon 28 Texas Administrative Code §133.20(e)(2). The respondent contends that reimbursement is not due "based on failure to accurately submit medical billing data in accordance with division rules set forth for a licensed provide."

   CPT code 73140 is defined as "Radiologic examination, finger(s), minimum of 2 views."

   The requestor wrote "This Xray was done at our facility we bill Radiologist for service."

   28 Texas Administrative Code §133.20(e)(2) states "A medical bill must be submitted: in the name of the licensed health care provider that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care."

   The Division reviewed the submitted medical records and supporting documentation and finds the following:

   - Dr. Jay C. Proctor is listed in box 31 of the medical bill.
   - The X-ray report is signed by Sinclair Cottingham, MD.
   - No documentation to support that Dr. Cottingham was an unlicensed individual providing the disputed healthcare that required Dr. Proctor's supervision.

   The Division finds that the requestor did not bill in accordance with 28 Texas Administrative Code §133.20(e)(2), because the medical bill was not submitted by the licensed health care provider who provided the service; therefore, 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

		06/10/2015
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, 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.