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
FONDREN ORTHOPEDIC GP, LLP

Respondent Name
TRAVELERS INDEMNITY CO

MFDR Tracking Number
M4-16-2960-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
MAY 25, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient had wrist surgery related to his workers' compensation injury…with subsequent pin removal…He was placed in an upper extremity immobilizer to protect his wrist. His shoulder became frozen due to the immobilization to protect the wrist. This is related to the injury, however, the office visit to diagnose this problem would not be global to the surgery as the evaluation was to a different area. Modifier-24 has been added to the office visit code to indicate this."

Amount in Dispute: $112.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider submitted billing for surgical follow-up, which the Carrier reviewed and denied reimbursement as the follow-up is included in the reimbursement for the surgical procedure."

Response Submitted By: The Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 12, 2015	CPT Code 99213-24 Office Visit	$112.25	$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 services in dispute were reduced/denied by the respondent with the following reason codes:
   - 97-Allowance included in another service.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
   - 947-Upheld no additional allowance has been recommended.
   - W3- Additional payment made on appeal/reconsideration.
   - 193- Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is the allowance of CPT code 99213-24 included in the allowance of another service?
2. Does the documentation support billing code 99213-24? Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for CPT code 99213-24 based upon reason code "97-Allowance included in another service."

   On the disputed date of service, the requestor billed CPT codes 99213-24 and 73100-LT.

   The requestor states "This is related to the injury, however, the office visit to diagnose this problem would not be global to the surgery as the evaluation was to a different area."

   The respondent wrote "As noted in the Provider's position statement, the office visit follow-up was to evaluate the Claimant for complications to the shoulder as a result of the wrist surgery. In the Carrier's view, this type of follow-up is no different than an infection occurring or stitched coming out following surgery. As the follow-up was directly related to the effects of the wrist surgery, the office visit follow-up is included in the surgical reimbursement for the primary procedure. The Carrier contends the use of the -24 modifier was inappropriate and separate reimbursement is not due for the disputed service."

   The issue in dispute is whether or not the August 12, 2015 office visit (CPT code 99213) is included in the global surgery package of the wrist surgery performed on May 20, 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."

   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.

A review of the submitted documentation finds that Dr. Alani 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 support using modifier 24 because the service was related to complications from treatment to the wrist surgery. Therefore, the Division finds that the disputed office visit is global to the global surgery package for the wrist surgery.

2. CPT code 99213 is defined as "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers 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. Physicians typically spend 15 minutes face-to-face with the patient and/or family."

   A review of the submitted medical report does not support at least two of the three key components for CPT code 99213; therefore, the requestor did not support billing CPT code 99213. 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

		06/23/2016
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, 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.