



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

KEVIN A. WILLIAMS, MD

Respondent Name

WAUSAU UNDERWRITERS INSURANCECO

MFDR Tracking Number

M4-17-2326-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

APRIL 3, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Position summary not included in the dispute packet.

Amount in Dispute: \$75.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Code 99212-25 was denied as included in the procedures/diagnostic testing. No significant separately identifiable Evaluation and Management service has been documented. Modifier 25 is for a significant separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service...The provider was paid for CPT 20610 and therefore the visit is included in the global period of CPT 20610."

Response Submitted by: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: November 17, 2016, CPT Code 99212-25 Office Visit, \$75.00, \$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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
• X212, 97-This procedure is included in another procedure performed on this date.
• 193, W3-The charge for this procedure exceeds the fee schedule allowance.

- U301, 18-This item has been reviewed on a previously submitted bill, or is currently in process. Notification of decision has been previously proceed or will be issued upon completion of our review.

## Issues

The issue in dispute is whether or not the November 17, 2016 office visit (CPT code 99212) is included in the global surgery package of CPT code 20610?

## Findings

1. The insurance carrier denied reimbursement for the office visit, CPT code 99212-25, based upon reason code "X212, 97-This procedure is included in another procedure performed on this date."

On the disputed date of service, the requestor billed codes 20610-LT, 99212-25-57, J1040, and J2001. The respondent contends that reimbursement is not due because the requestor did not support billing for an office visit in conjunction with procedure code 20610-LT.

2. 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."

3. Codes 99212 and 20610 are defined as:

- a. CPT code 99212 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: A problem focused history; A problem focused examination; Straightforward medical decision making. 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 self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family."

The requestor appended modifiers 25 and 57 that are defined as:

- 25- "Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service."
  - 57- "Decision for Surgery."
- b. CPT code 20610 as "Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance."

The requestor appended modifier LT-"Left Side" to code 20610.

4. Is the provider's billing of modifier "57" supported?

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

CPT code 20610 has a 0-day postoperative period; therefore, per *Medicare Claims Processing Manual*, Chapter 12, (40.2)(A), it is categorized as a minor procedure.

The Medicare policy regarding modifier “57” is found at *Medicare Claims Processing Manual, Chapter 12, (40.2)(A)(4), Billing Requirements for Global Surgery* which states:

Evaluation and Management Service Resulting in the Initial Decision to Perform Surgery  
Evaluation and management services on the day before major surgery or on the day of major surgery that result in the initial decision to perform the surgery are not included in the global surgery payment for the major surgery and, therefore, may be billed and paid separately. In addition to the CPT evaluation and management code, modifier “-57” (decision for surgery) is used to identify a visit which results in the initial decision to perform surgery. (Modifier “-Q1” was used for dates of service prior to January 1, 1994.)

If evaluation and management services occur on the day of surgery, the physician bills using modifier “-57,” not “-25.” The “-57” modifier is not used with minor surgeries because the global period for minor surgeries does not include the day prior to the surgery. Moreover, where the decision to perform the minor procedure is typically done immediately before the service, it is considered a routine preoperative service and a visit or consultation is not billed in addition to the procedure.

Because code 20610 is considered a minor surgery, per *Medicare Claims Processing Manual, Chapter 12, (40.2)(A)(4)*, the “The “-57” modifier is not used with minor surgeries because the global period for minor surgeries does not include the day prior to the surgery. Moreover, where the decision to perform the minor procedure is typically done immediately before the service, it is considered a routine preoperative service and a visit or consultation is not billed in addition to the procedure.” The division finds the requestor did not support billing modifier 57 with the office visit.

5. Is the provider’s billing of modifier “25” supported?

*Medicare Claims Processing Manual, Chapter 12, (40.2)(A)(8), Billing Requirements for Global Surgery* states:

Significant Evaluation and Management on the Day of a Procedure

Modifier “-25” is used to facilitate billing of evaluation and management services on the day of a procedure for which separate payment may be made. It is used to report a significant, separately identifiable evaluation and management service by same physician on the day of a procedure. The physician may need to indicate that on the day a procedure or service that is identified with a CPT code was performed, the patient’s condition required a significant, separately identifiable evaluation and management service above and beyond the usual preoperative and postoperative care associated with the procedure or service that was performed. This circumstance may be reported by adding the modifier “-25” to the appropriate level of evaluation and management service.

A review of the submitted medical report finds that the requestor did not support “a significant, separately identifiable evaluation and management service above and beyond the usual preoperative and postoperative care associated with the procedure or service that was performed.” Therefore, the Division finds that the disputed office visit is global to code 20610. 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

\_\_\_\_\_  
Date

04/20/2017

***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.**