



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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

DR SERGIO RODRIGUEZ

Respondent Name

STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number

M4-13-0333-01

Carrier's Austin Representative Box

Box Number 45

MFDR Date Received

October 1, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am asking for reconsideration for payment pertaining to an Evaluation/consultation performed...on 2/17/2012 in the amount of \$198.64 for the above named patient."

Amount in Dispute: \$397.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...the Office will maintain the denials of 97- Payment is included in the allowance for another service/procedure for CPT code 99214 for dates of service 2/17/2012 and 4/4/2012. Further review determined that the requestor performed services on 2/10/2012 utilizing CPT code 26775 (Exhibit I), where there is a 1 day preoperative and 90 day postoperative period included in the fee schedule payment of this code pursuant to the Medicare Fee Schedule (Exhibit II)."

Response by: State Office Of Risk Management.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 17, 2012 through April 4, 2012	99214	\$397.28	\$0

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for E/M services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- W1-Workers compensation state fee schedule adjustment.
- 193- Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 97- The benefit for this service is included in the pymt/allowance for another service/procedure that has already been adjudicated.

- R02- Services rendered are within the global package shall be denied.

Issues

1. Did the requestor appropriately bill for E&M services following a surgery?
2. Is the requestor entitled to reimbursement ?

Findings

1. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, “for coding, billing reporting, and reimbursement of professional medical services, Texas Workers’ Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; ... and other payment policies in effect on the date a service is provided...”

In its position statement, the carrier states in pertinent part “Further review determined that the requestor performed services on 2/10/2012 utilizing CPT code 26775...where there is a 1 day preoperative and 90 day postoperative period included in the fee schedule payment of this code pursuant to the Medicare Fee Schedule...”

Per Medicare Claims Processing Manual, Chapter 12, Section 40.1 and 40.2 state in pertinent part-- the components of a global surgical package include:

- Preoperative Visits - Preoperative visits after the decision is made to operate beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures;
- Intra-operative Services - Intra-operative services that are normally a usual and necessary part of a surgical procedure;
- Complications Following Surgery - All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room;
- Postoperative Visits - Follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery;
- Postsurgical Pain Management - By the surgeon;
- Supplies - Except for those identified as exclusions; and
- Miscellaneous Services - Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

Section 40.2 states “7. Unrelated Procedures or Visits During the Postoperative Period. 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.”

Review of the documentation submitted by the requestor for service date February 17, 2012 states in pertinent part “...female who is here for follow-up visit. She sustained a dislocation of her left small finger proximal interphalangeal joint one week ago. She underwent emergency close reduction under anesthesia in my office...We will discontinue the ulnar gutter splint...”

Review of the documentation submitted by the requestor for service date April 4, 2012 states in pertinent part “On physical exam however her range of motion is decreased.”

The division concludes that the documentation submitted does not support that the services billed are unrelated to the surgery performed on 2/10/12.

2. For the reasons stated above, the services in dispute for dates February 17, 2013 and April 4, 2012 are not eligible for payment pursuant to 28 TAC §134.203 (c).

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional 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

April 25, 2014

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.