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Commonwealth Court Defines What Constitutes "a Significant and Separately Identifiable Service"

In the case of first impression, the Commonwealth Court recently addressed what constitutes a "significant and separately identifiable service" performed in addition to another procedure under the Workers' Compensation Medical Cost Containment Regulations. The facts are relatively simple. The injured worker treated with a chiropractor. The chiropractor billed the insurance carrier for an office visit in addition to charges for the specific modalities provided during each visit.

The insurance carrier denied payment for the office visit charges but paid the other treatments. The provider then filed a series of application for fee review.

Section 306 (f.1) of the Workers' Compensation Act and the Medical Cost Containment Regulations require Healthcare providers to bill for their treatment in accordance with the Medicare procedure codes and limits payment to providers based upon Medicare reimbursement rates. Furthermore, Section 127.105 of the Medical Cost Containment Regulations governs payment to chiropractors and states "payment shall be made for an office visit provided on the same day as another procedure only when the office visit represents a significant and separately identifiable service performed in addition to the other procedure." The Medical Cost Containment Regulations do not define the phrase "significant and separately identifiable service" or "significant and separately identifiable."

Therefore, the Court looked to federal Medicare case law and administrative decisions which have held that an examination or evaluation on the same date as another procedure does not constitute "Significant and Separately Identifiable Service" unless it is above and beyond the usual evaluation performed in conjunction with that procedure or is unrelated to the procedure that was performed on the same day. In particular, consultations were not "significant and separately identifiable services." However, an evaluation is a significant and separately identifiable service" only if a patient's condition required an evaluation above and beyond the usual pre-operative or post-operative work of the procedure, in evaluations and close proximity in time with no significate changes in medical condition do not satisfy the significant and separately identifiable service requirement. Furthermore, the Centers for Medicare and Medicaid Services (the CMS) states with respect to chiropractors "Chiropractors will be allowed to bill Medicare for both an evaluation and management visit and for the treatment the first time the chiropractor assess a patient as well as for current patients in such instances as we know as a new condition, exacerbation or recurrence of the current condition or for a reassessment midway through treatment. Chiropractors should not bill for an evaluation and management visit service every time the treat a patient."

The Court, utilizing the language above, concluded that an examination involving no new medical condition, change in medical condition or other circumstances that requires an examination and assessment above and beyond the usual examination and evaluation for the treatment performed on the same date does not constitute a "significant and separately identifiable service" for which a chiropractor may be paid an additional fee. The case was remanded to the fee Review Hearing Office to make those determinations.

It is also significant to note that the question of what constitutes a significant and separately identifiable service is an issue of law, not an issue of fact. Accordingly, these charges are fully reviewable on appeal to the Commonwealth Court and are not bound by the credibility and factual determinations of the Fee Review Hearing Officer.

Comment: In light of this decision, it is our recommendation that you carefully review each and every chiropractor bill presented to you. If the chiropractor bills for a separate office visit in addition to the charges

for the specific services provided, payment should be made for the specific services and not for the office visit. Should the provider challenge that decision though an application for fee review, carriers may rely upon this case to support their payment decisions. Similarly, should a Penalty Petition be filed for failing to pay for specific treatment, this case can be used to defend such petitions. The case may be found at 1033 CD 2016 and the case name is Sedgwick Claims Management Services v. Bureau of Workers' Compensation Fee Review Hearing Office (Piszel and Bucks County Pain Center).