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
James Weiss MD

Respondent Name
Employers Insurance Co of Wausau

MFDR Tracking Number
M4-17-3810-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
August 22, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and compliance with TDW-DWC Rule 133 and 134."

Amount in Dispute: $154.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…CPT Code 99204 was billed in combination with codes 95911 and 95886 which have "XXX" and "ZZZ" global days. Medicare indicates that E&M should not be billed with "XXX" procedures since the procedure components include the pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is complete. Codes with "ZZZ" global days indicates the services are included in the global period of another related service… HCPCS Codes A4556 and A4215 were denied as bundled or non-covered procedure based on Medicare guidelines; no separate payment allowed.

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 11, 2017	99204, A4556, A4215	$154.44	$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 §134.203 sets out the reimbursement guidelines for professional medical

services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - X212 – This procedure is included in another procedure performed on this date
   - 193 – This procedure is included in another procedure performed on this date
   - W3 – This procedure is included in another procedure
   - MSCP – In accordance with the CMS Physician Fee Schedule Rule for status code "P", this service is not separately reimbursed when billed with other payable services
   - B291 – This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed

Issues

1. Was the office visit billed in accordance with fee guideline?
2. Is HCPCS cod A4556 and A4215 eligible for review?

Findings

1. The requestor is seeking reimbursement in the amount of $154.44 for professional medical services rendered on April 11, 2017.

   The codes in dispute are:

   - 99204 - Office or other outpatient visit for the evaluation and management of a new patient,
   - A4556 – Electrodes (e.g., apnea monitor), per pair
   - A4215 - Needle, sterile, any size, each

   The insurance carrier denied disputed services 99204 with claim adjustment reason code 97 – X212 "This procedure is included in another procedure performed on this date."

   Codes A4556 was denied as MSCP – "In accordance with the CMS Physician fee schedule rule for status code "P", this service is not separately reimbursed when billed with other payable services and A4215 was denied as B291 – "This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed." on both medical bills.

   Each of the codes in dispute are discussed below.

   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."

   CPT code 99204 is defined as "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. 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 of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family."

   On the disputed date of service, the requestor billed for CPT code 99204, 95886, 95910, A4556 and A4215.

   Per Medicare fee schedule, CPT code 95886 has a global surgery period of "ZZZ" and code 95910 has "XXX."

   The National Correct Coding Initiative Policy Manual, at www.cms.gov, effective January 1, 2017, Chapter I, General Correct Coding Policies, section D, states:

   > All procedures on the Medicare Physician Fee Schedule are assigned a Global period of 000, 010, 090, XXX, YYY, ZZZ, or MMM. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the Carrier (A/B MAC processing practitioner service claims). All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure…

Procedures with a global surgery indicator of "XXX" are not covered by these rules. Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other "XXX" procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most "XXX" procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same date of service which may be reported by appending modifier 25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the "XXX" procedure but cannot include any work inherent in the "XXX" procedure, supervision of others performing the "XXX" procedure, or time for interpreting the result of the "XXX" procedure. Appending modifier 25 to a significant, separately identifiable E&M service when performed on the same date of service as an "XXX' procedure is correct coding.

The Division finds that the requestor did not identify a significant and separate E&M service to support billing CPT code 99204 in conjunction with CPT codes 95886 and 95910. In addition, the requestor did not append modifier 25 to CPT code 99204 per the correct coding guidelines. Therefore, the Division finds that the carrier's position is supported. As a result, reimbursement is not recommended.

2. The respondent states, "HCPCS Codes A4556 and A4215 were denied as bundled or non-covered procedure based on Medicare guidelines; no separate payment allowed."

   Review of the applicable Medicare payment policy for each of these disputed codes finds:

   - Code A4556 – Status Code "P" Bundled/Excluded Codes
   - Code A4215 – Status Code "X" Statutory Exclusion

   Based on the above, the Carrier's denial and response is supported. No separate reimbursement recommended.

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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		September 13, 2017
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 Rule §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 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. **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.