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**
Ahmed Khalifa MD

**Respondent Name**
Liberty Insurance Corp

**MFDR Tracking Number**
M4-18-2777-01

**Carrier's Austin Representative**
Box Number 01

**MFDR Date Received**
March 30, 2018

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The carrier has reduced this claim inappropriately and not in accordance and compliance with TDI-DWC Rule 133 and 134. The carrier has not responded or denied this claim in its entirety following our filing of Request for Reconsideration."

**Amount in Dispute:** $454.20

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "CPT Code 99202 was billed in combination with codes 95909 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 … HCPCS Codes A4556, electrodes per pair, and A4215, needle sterile any size, were denied as supplies are not separately payable per Medicare guidelines."

**Response Submitted by:** Liberty Mutual

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| May 04, 2017 | Code 95886<br>Needle electromyography | $299.76 | $0.00 |
| | Code 95910<br>Nerve conduction study | $0.00 | |
| | Code A4556<br>Electrodes | $16.90 | |
| | Code A4215<br>Needle Sterile | $15.00 | |
| | Code 99202-59<br>New office outpatient visit | $122.54 | |
| Total | | $454.20 | |

## *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, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - X133 – This charge was not reflected in the report as one of the procedures or services performed
   - PNFC – The reimbursement is based on the CMS physician fee schedule non facility site of service rate
   - B291 – This is a bundled or non covered procedure based on Medicare Guidelines; no separate payment allowed
   - MSCP – In accordance with the CMS physician fee schedule for status Code 'P', this service is not separately reimbursed when billed with other payable services
   - 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 P
   - B13 – The reimbursement is based on CMS physician fee schedule non-facility site of service rate

**Issues**

1. What is the applicable fee guideline for professional services?
2. Was the office visit billed in accordance with fee guidelines? Is the requestor entitled to reimbursement?
3. Is allowance for Code A4556 included in the allowance of another service performed on this date?
4. Is allowance for Code A4215 included in the allowance of another service performed on this date?

**Findings**

1. The fee guidelines for disputed services are in 28 Texas Administrative Code §134.203.

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 .

   CPT code 99202 is defined as "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded 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 of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family."

   The requestor appended modifier "59-Distinct Procedural Service" to code 99202.

   Modifier "59" is defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

Review of the submitted documentation does not support a "different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) no ordinarily encountered or performed on the same day by the same individual." The division finds the requestor has not supported the use of modifier "59."

On the disputed date of service, the requestor originally billed 99204, 95886, 95910, A4556 and A4215. Then down coded 99204 to 99202.

Per 28 Texas Administrative Code §134.203(a)(5), the Division referred to Medicare's coding and billing policies. 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, effective January 1, 2016, 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.
Per Medicare policy, "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." The Division finds that the requestor's E&M report did not meet all three required key components for billing CPT code 99202. In addition, the requestor did not code for the service in accordance with Medicare policies. As a result, reimbursement is not recommended.

3. The requestor is seeking medical dispute resolution for $16.90 for Code A4556. Code A4556 is defined as "Electrodes (e.g., apnea monitor), per pair). The respondent denied reimbursement with denial codes "MSCP – In accordance with the MSC physician fee schedule rule for status code 'P', this service is not separately reimbursed when billed with other payable services", "193 – This procedure is included in another procedure performed on this date" and "W3 – This procedure is included in another procedure performed on this date."

   Per Medicare guidelines, Transmittal B-03-020, effective February 28, 2003 if Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) HCPCS codes are incidental to the physician service, it is not separately payable. A review of the submitted documentation does not support a separate service to support billing HCPCS code A4556. As a result, reimbursement is not recommended.

4. The requestor is seeking medical dispute resolution for $15.00 for Code A4215. Code A4215 is defined as "Needle, sterile, any size, each." The respondent denied reimbursement with denial codes "B291 – This is a bundled or non covered procedure based on medicare guidelines; no separate payment allowed" and "193 – This procedure is included in another procedure performed on this date."

Per Medicare guidelines, Transmittal B-03-020, effective February 28, 2003 if Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) HCPCS codes are incidental to the physician service, it is not separately payable. A review of the submitted documentation does not support a separate service to support billing HCPCS code A4215 in conjunction with CPT codes 95886 and 95910. As a result, reimbursement is not 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**

| | | |
|---|---|---|
| | | 6/1/2018 |
| 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**.