



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

IKECHUKWU OBIH, MD

Respondent Name

LIBERTY INSURANCE CO

MFDR Tracking Number

M4-19-3934-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

APRIL 26, 2019

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: \$866.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT code 99203-25 (Evaluation and management) was denied as Modifier 25 was not supported...HCPCS Codes A4556 and A4215 represents supplies (electrodes and needles) used in the testing. The cost of these supplies is considered included in the allowance for the EMG and NCS fee schedule allowance as they are inherent to the procedure and not above the normal supplies for these type tests."

Response Submitted By: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Rows include services like CPT Code 99203-25, CPT Code 95886 (X2), CPT Code 95911, HCPCS Code A4556, and HCPCS Code A4215, with a TOTAL row at the bottom.

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

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 services in dispute were reduced / denied by the respondent with the following reason code:
 - 242, 5884-Provider is not within the Liberty Health Care Network (HCN) for this customer. Insurance Code 1305.004(B) and Labor Code 401.011.
 - P12, 876-Fee schedule amount is equal to the charge.
 - 97-Payment is included in the allowance for another service/procedure.
 - 243-The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
 - W3-Additional payment made on appeal/reconsideration.
 - 193-The original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Does a network issue exist in this dispute?
2. What is the applicable fee guideline for professional services?
3. Was the office visit billed in accordance with fee guideline? Is the requestor entitled to reimbursement?
4. Is the allowance of HCPCS code A4556 included in the allowance of another service performed on this date?
5. Is the allowance of HCPCS code A4215 included in the allowance of another service performed on this date?

Findings

1. The requestor initially denied reimbursement for the disputed services based upon reason codes "242" and "5884." Upon reconsideration, the respondent did not maintain the denial of payment and issued payment of \$664.21 for CPT codes 95886 and 95911.
2. The fee guidelines for disputed services are found in 28 Texas Administrative Code §134.203.
3. 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 99203 is described as "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low 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 severity. Typically, 30 minutes are spent face-to-face with the patient and/or family."

The requestor appended modifier 25 to code 99203. Modifier 25 is described as "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."

On the disputed date of service, the requestor billed for CPT code 99203-25, 95911, and 95886. 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 95911 has "XXX."

The National Correct Coding Initiative Policy Manual, effective January 1, 2018, 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 period of MMM are maternity procedures. ... 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 *shall not* 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 *shall not* 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 work *shall not* be reported as a separate E&M code." The Division finds that the requestor's E&M report did not meet all three required key components for billing CPT code 99203. In addition, the requestor did not code for the service in accordance with Medicare policies. As a result, reimbursement is not recommended.

4. Based upon the submitted explanation of benefits, the respondent issued payment of \$664.21 for CPT code 95886 and 95911. To determine if the requestor is due additional reimbursement the division refers to the fee guideline.

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2018 DWC conversion factor for this service is 58.31.

The Medicare Conversion Factor is 35.9996

Review of Box 32 on the CMS-1500 the services were rendered in San Antonio, Texas; therefore, the locality will be based upon "Rest of Texas."

The Medicare participating amount for code 95886 in San Antonio, Texas is \$89.51.

Using the above formula, the MAR is $\$144.98 \times 2 = \289.96 . The requestor is seeking a lesser amount of \$289.00. The respondent paid \$289.00. As a result, the requestor is not due additional reimbursement for code 95886.

For code 95911, the Medicare participating in San Antonio, Texas is \$232.51.

Using the above formula, the MAR is \$376.61. The requestor is seeking a lesser amount of \$375.21. The respondent paid \$375.21. As a result, the requestor is not due additional reimbursement for code 95911.

5. The requestor is seeking medical dispute resolution for \$16.90 for HCPCS code A4556.

HCPCS code A4556 is defined as "Electrodes (e.g., apnea monitor), per pair."

The respondent denied reimbursement based upon reason codes "97-Payment is included in the allowance for another service/procedure," and "243-The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed."

Per Medicare physicians' fee schedule, code A4556, is a status "P" code.

Status "P" codes are defined as "Bundled/excluded codes. There are no RVUs and no payment amounts for these services. No separate payment is made for them under the fee schedule. If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician service). If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (for example, colostomy supplies) and is paid under the other payment provision of the Act."

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.

6. The requestor is seeking medical dispute resolution for \$15.00 for HCPCS code A4215.

HCPCS code A4215 is defined as "Needle, sterile, any size, each."

The respondent denied reimbursement based upon reason codes "97-Payment is included in the allowance for another service/procedure," and "243-The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed."

Per Medicare guidelines, [Transmittal B-03-020](#), the documentation does not support a separate service to support billing HCPCS code A4215 in conjunction with CPT codes 95886 and 95911. 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.

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

05/22/2019
Date

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.