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
GRANITE STATE INSURANCE CO

MFDR Tracking Number
M4-19-4310-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JUNE 3, 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: $77.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After review, the Carrier maintains that the Provider was paid correctly. For procedure code A4556, the payment for this service is bundled into the payment of other services. For procedure code A4215, the supplies are included in the global allowance. Therefore, no additional amount is due to the Provider."

Response Submitted By: AIG

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 8, 2018	CPT Code 99203-25 New Patient Office Visit	$9.29	$0.00
	CPT Code 95886(x2) Needle EMG	$17.38	$0.00
	CPT Code 95910 Nerve Conduction Studies	$18.55	$0.00
	HCPCS Code A4556 Electrodes	$16.90	$0.00
	HCPCS Code A4215 Needles	$15.00	$0.00
TOTAL		$77.12	$0.00

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, effective May 31, 2012, 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 claim adjustment reason code(s):
   - 1- Workers' compensation jurisdictional fee schedule adjustment.
   - 2-Workers' compensation medical treatment guideline adjustment.
   - 3-The charge for the procedure exceeds the amount indicated in the fee schedule.
   - 4-No additional reimbursement allowed after review of appeal/reconsideration.
   - 5-Modifier 50 or LT/RT has been billed identifying bilateral procedures. Payment is based on the bilateral reimbursement policy for both procedures.
   - 6-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 7-The payment for this service is bundled into payment of other services.
   - 8-Supplies and/or services included in the global surgical or anesthetic allowance.
   - 9-Our position remains the same. We have received no documentation that would alter our original recommendation.

Issues

1. Was the office visit billed in accordance with fee guideline? Is the requestor entitled to additional reimbursement?
2. Is the requestor entitled to additional reimbursement for CPT codes 95910 and 95886?
3. Is the allowance of HCPCS code A4556 included in the allowance of another service performed on this date?
4. Is the allowance of HCPCS code A4215 included in the allowance of another service performed on this date?

Findings

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

   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 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" to code 99203.

   Modifier "25" is defined as "It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative

care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service."

The EMG/NCV Consultation and Testing report states "PURPOSE/REASON FOR THIS EVALUATION AND TESTING: The above examinee was referred for Electromyography Testing (EMG/NCV) with consultation."

On the disputed date of service, the requestor billed CPT code 99203-25, 95910, 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 95910 has "XXX.

The National Correct Coding Initiative Policy Manual, effective January 1, 2018, Chapter I, General Correct Coding Policies, section D, states:

> Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.
> 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.
> Since NCCI PTP edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances… If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. In general E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and *shall* not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure.

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 report does not support "a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure".

The division finds per 28 Texas Administrative Code §134.203(c)(1)(2), the MAR for CPT code 99203 is $170.71. The respondent paid $170.71. As a result, additional reimbursement is not recommended.

2. The requestor is seeking additional reimbursement for CPT codes 95886(X2) and 95910.

   To determine if additional reimbursement is due, the division refers to 28 Texas Administrative Code §134.203(c)(1)(2).

   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 reimbursement is based upon locality "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 X 2 = $289.96. The respondent paid $289.96. As a result, the requestor is not due additional reimbursement for code 95886.

- The Medicare participating amount for code 95910 in San Antonio, Texas is $194.69.

  Using the above formula, the MAR is $315.35. The respondent paid $315.35. As a result, the requestor is not due additional reimbursement for code 95910.

3. 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 unbundling.

   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.

4. 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 unbundling.

   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 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

		06/27/2019
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 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.