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
TEXAS BACK INSTITUTE

Respondent Name
EMPLOYERS INSURANCE CO OF WAUSAU

MFDR Tracking Number
M4-19-4831-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
JULY 11, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Usually an E&M service is included in the exam performed just prior to and during nerve conduction studies and/or electromyography. If the E&M service is a separate and identifiable service, the medical record must document medical necessity and the CPT code must be bill with a modifier 25."

Amount in Dispute: $286.11

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Code 99203 25 was denied as this was not for a separate issue from the testing. The codes billed 95909 and 95886 have 'XXX' global days. The references to 'XXX' global day procedures indicate that evaluation and management should not be billed since the procedure components include the pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed…Since this was not for other than the normal pre and post procedure work, this code is not payable. Code 95886 which is denied, is payable and was denied in error. The bill has been adjusted and copies of EOBs are attached for your review."

Response Submitted By: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 16, 2018	CPT Code 99203-25	$153.87	$0.00
	CPT Code 95886-59	$132.29	$0.00
TOTAL		$286.11	$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, 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 out the reimbursement guidelines for professional services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment code:
   - 886-The procedure was inappropriately billed. The provider has previously billed for an initial/evaluation visit.
   - 10-The billed service requires the use of a modifier code.
   - W3-Additional payment made on appeal/reconsideration.

Issues

Is the requestor entitled to reimbursement for CPT codes 99203-25 and 95886-59 rendered on July 16, 2018?

Findings

1. The fee guidelines for disputed services is found at 28 Texas Administrative Code §134.203.
2. On the disputed dates of service, the requestor billed CPT codes 95909, 99203-25, 95886 and 95886-59. Only codes 99203-25 and 95886-59 are in dispute.
3. According to the explanation of benefits, the respondent originally denied reimbursement for CPT code 95886-59 based upon "10-The billed service requires the use of a modifier code." The respondent did not maintain the denial and wrote, "Code 95886 which is denied, is payable and was denied in error. The bill has been adjusted and copies of EOBs are attached for your review." In support of the position the respondent submitted a copy of an EOB and check for $144.98.

   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).

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 75028, which is in Flower Mound, Texas; therefore, the Medicare participating amount is based on locality "Rest of Texas".

   The 2018 DWC conversion factor for this service is 58.31.

   The Medicare conversion factor is 35.9996.

   The Medicare participating amount is $89.51.

   Using the above formula, the Division finds the MAR is $144.98. The respondent paid $144.98; therefore, additional reimbursement is not recommended.
4. 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 defined 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."

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 95909 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.

The division finds per the National Correct Coding Initiative Policy Manual, Chapter I, section D, the requestor has not identify a significant and separate E&M service to support billing CPT code 99203 in conjunction with CPT codes 95886 and 95909. 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 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 services in dispute.

Authorized Signature

		08/07/2019
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.