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**
LM INSURANCE CORP

**MFDR Tracking Number**
M4-19-5074-01

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

**MFDR Date Received**
AUGUST 1, 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…DESIGNATED DOCTOR REFERRED TESTING…NO PRE-AUTHORIZATION IS REQUIRED."

**Amount in Dispute:** $931.99

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Code 99203 25 was denied as this was not for a separately identifiable reason separate from the testing…95911 was denied as this code is for Nerve conduction studies; 9-10 studies. Per the report motor test were done on the left median and ulnar; sensory tests on the left median, ulnar and radial. The compensable injury is to the left hand, and therefore the right side is not payable. 95886 right was denied as this is not compensable. 95886 left is denied as there is no paying primary code and this is an add on code. A4556 and A4215 are denied as supplies commonly used are inclusive in the procedure."

**Response Submitted By:** Liberty Mutual Insurance Co.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| January 17, 2019 | CPT Code 99203-25<br>New Patient Office Visit | $182.47 | $0.00 |
| | CPT Code 95886(X2)<br>Needle EMG | $321.05 | $321.05 |
| | CPT Code 95911<br>Nerve Conduction Studies | $396.57 | $396.57 |
| | HCPCS Code A4556<br>Electrodes | $16.90 | $0.00 |
| | HCPCS Code A4215<br>Needles | $15.00 | $0.00 |
| TOTAL | | $931.99 | $717.62 |

## *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 §127.10 effective September 1, 2012 sets out the Designated Doctor procedures and requirements.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
4. The services in dispute were reduced / denied by the respondent with the following reason code:
   - 5882-Pre-authorization was requested but denied for this service per DWC rule 134.600.
   - 97-Payment is included in the allowance for another service/procedure.
   - 47-Office visit/evaluation included in the value of another procedure.
   - 107-Code description not given.
   - 292- Code description not given.
   - 11- Code description not given.
   - 5796- Code description not given.
   - 243- Code description not given.
   - W3-Additional payment made on appeal/reconsideration.
   - X598-Claim has been re-evaluated based on additional documentation submitted; no additional payment due.

### Issues

Is the requestor eligible for reimbursement for disputed services rendered on January 17, 2019?

### Findings

1. The respondent states, "The compensable injury is to the left hand, and therefore the right side is not payable."

   28 Texas Administrative Code §133.307(d)(2)(F) states "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section."

   The Division finds that the respondent raises issues in the position summary that were not presented to the requestor prior to the date the request for MFDR was filed with the division. A review of the submitted explanation of benefits does not list any denial reasons to support the issues raised in the position summary; therefore, the response was not submitted in accordance with 28 Texas Administrative Code §133.307.

2. According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon reason code "5882-Pre-authorization was requested but denied for this service per DWC rule 134.600."

   28 Texas Administrative Code §127.10(c) states in part, "The designated doctor shall perform additional testing when necessary to resolve the issue in question. The designated doctor shall also refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question and the designated doctor is not qualified to fully resolve the issue in question. Any additional testing or referral required for the evaluation is not subject to preauthorization requirements nor shall those services be denied retrospectively based on medical necessity, extent of injury, or compensability in accordance with the Labor

Code §408.027 and §413.014, Insurance Code Chapter 1305, or Chapters 10, 19, 133, or 134 of this title (relating to Workers' Compensation Health Care Networks, Agents' Licensing, General Medical Provisions, and Benefits--Guidelines for Medical Services, Charges, and Payments, respectively) but is subject to the requirements of §180.24 of this title (relating to Financial Disclosure)."

The requestor noted that the claimant was referred by the Designated Doctor Enas Pruitt for evaluation and testing; therefore, per 28 Texas Administrative Code §127.10(c) the testing did not require preauthorization. The division finds the respondent's denial based upon a lack of preauthorization is not supported.

3. 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, 95911, 95886, A4556 and A4215. 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, 2019, 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...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… 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, intraprocedure, 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 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".

4. The requestor is seeking reimbursement for CPT codes 95886(X2) and 95911.

   To determine if 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 2019 DWC conversion factor for this service is 59.19.

The Medicare Conversion Factor is 36.0391

Review of Box 32 on the CMS-1500 the services were rendered in Houston, Texas; therefore, the reimbursement is based upon locality "Houston, Texas".

Using the above formula, the MAR is:

| Code | Medicare Participating Amount | MAR | Insurance Carrier Paid | Amount Due |
|---|---|---|---|---|
| 95886 (X2) | $97.88 | 160.76 X 2 = $321.51 or less. Requestor is seeking $321.05 | $0.00 | $321.05 |
| 95911 | $241.81 | $397.14 or less. The Requestor is seeking $396.57 | $0.00 | $396.57 |

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 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.

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 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 95911. As a result, reimbursement is not recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that reimbursement of $717.62 is due.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $717.62 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | 08/22/2019<br>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**.