TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
IKECHUKWU OBIH, MD

Respondent Name
ZNAT INSURANCE CO

MFDR Tracking Number
M4-20-0503-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
OCTOBER 23, 2019

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: $295.73

RESPONDENT'S POSITION SUMMARY

"Zenith is recommending an additional payment of $263.83 for 99204-25…the disputed HCPCS codes were correctly disallowed…$263.83 (Will be processed once Zenith received the MFDR order)."

Response Submitted By: The Zenith

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 31, 2019	CPT Code 99204-25 New Patient Office Visit	$263.83	$0.00
	CPT Code 95886 Needle EMG	$0.00	$0.00
	CPT Code 95912 Nerve Conduction Studies	$0.00	$0.00
	HCPCS Code A4556 Electrodes	$16.90	$0.00
	HCPCS Code A4215 Needles	$15.00	$0.00
TOTAL		$295.73	$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 (DWC).

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 reason code:
   - XCD-Procedure modifier was invalid on the date of service.
   - 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 629-The medically unlikely edits (MUE) from CMS has been applied to this procedure code.
   - 224-TX Duplicate Charge.
   - 18-Exact duplicate claim/service.

Issues

Is the requestor eligible for reimbursement for disputed services rendered on July 31, 2019?

Findings

1. The fee guidelines for disputed services are found in 28 TAC §134.203.
2. 28 TAC §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 99204 is described as "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate 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 to high severity. Typically, 45 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 99204.

   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 99204-25, 95912, 95886, A4556 and A4215. Per 28 Texas Administrative Code §134.203(a)(5), the DWC referred to Medicare's coding and billing policies. Per Medicare fee schedule, CPT code 95886 has a global surgery period of "ZZZ" and code 95912 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 DWC 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".

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 and MUEs.

   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 and MUEs.

   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 DWC finds that the requestor has not established that additional reimbursement is due.

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

		11/15/2019
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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **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.