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
JAMES WEISS MD

Respondent Name
OLD REPUBLIC GENERAL INSURANCE

MFDR Tracking Number
M4-20-2131-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
May 4, 2020

Response Submitted by:
Gallagher Bassett

REQUESTOR'S POSITION SUMMARY

"Service codes and CPT codes are not to be bundled nor compounded and are to be billed and reimbursed separately and independently from one another. You will note in the attached narrative report and testing results all required and billed components were performed and documented appropriately utilizing the above TDI-DWC Fee Guidelines and should not be reduced… Additionally, as you can see from the attached report an examination was performed and documented as a Detailed Examination component and billed as 99202 [sic]. See report for all 6[sic] elements required for a general multi-system examination."

RESPONDENT'S POSITION SUMMARY

"It appears the patient was seen by this provider for an initial visit on 7/30/19, so they are already established. The notes do not indicate a clear separate E/M service was performed, only a comparison EMG/NCS... A4556… There are no RVUs and no payment amounts for these services. No separate payment should be 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."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 22, 2020	Evaluation & Management (99214-25)	$183.29	$0.00
January 22, 2020	Needle Electromyography, each extremity (95886)	$0.00	$0.00
January 22, 2020	Nerve Conduction Studies, 9-10 studies (95911)	$0.00	$0.00
January 22, 2020	Electrodes, per pair (A4556)	$16.90	$0.00
January 22, 2020	Needle, sterile, any size, each (A4215)	$14.14	$0.00
TOTAL		$213.33	$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 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 00576 – (234) This procedure is not paid separately
   - 0072 – (4) This procedure code is inconsistent with the modifier used or a required modifier is missing
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 00216 – (P5) Based on payer reasonable and customary fees, no maximum allowable defined by legislated fee arrangement
   - Z711 –The charge for this procedure exceeds the customary charges by other providers for this service
   - 00086 18 – Exact duplicate claim service
   - 00214 – (W3) Additional payment made on appeal/reconsideration

Issues

1. What are the services in dispute?
2. What are the applicable rules for the disputed services?
3. Did the insurance carrier issue payment for disputed HCPCs code A4215?
4. Is the insurance carrier's denial reason for CPT code 99214-25 supported?
5. Is the insurance carrier's denial reason for HCPCs code A4556 supported?

Findings

1. The requestor billed for CPT /HCPC codes 99214-25, 95886, 95911, A4556, and A4215 on January 22, 2020. The DWC060 Table of Dispute Services identifies that the requestor not seeking reimbursement for CPT Codes 95886 and 95911, as the insurance carrier reimbursed the requestor for these services. Therefore, these services will not be considered in this dispute. The requestor seeks reimbursement in the amount of $213.33 for procedure codes 99214-25, A4556, and A4215. These services are reviewed pursuant to applicable rules and guidelines.

2. Reimbursement for the disputed codes are subject to the fee guidelines for professional medical services found in 28 TAC §134.203(b)(1), which states, in pertinent part:

   > For coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following:
   > (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…

3. The requestor seeks reimbursement for HCPCs code A4215 rendered on January 22, 2020. The insurance carrier denied the disputed service with claim adjustment reason codes 00216, P5, W3 and Z711 (description provided above).

   Medicare payment policy finds that HCPCs code A4215 has a status of Statutory Exclusion, which means,

   > These codes represent an item or service that is not in the statutory definition of "physician services" for fee schedule payment purposes. No RVUS or payment amounts are shown for these codes, and no payment may be made under the physician fee schedule…

   The DWC finds that reimbursement for this service cannot be recommended. As a result, $0.00 is recommended.

4. The insurance carrier denied disputed CPT Code 99214-25 with claim adjustment reason codes 0072, 4, P12 and W3 (description provided above).

   The division finds that procedure code 95911, billed by the requestor on the same date of service and reimbursed by the insurance carrier, has a global status of "XXX." Chapter I of the General Correct Coding Policies for *National Correct Coding Initiative Policy Manual for Medicare Services*, section D, effective January 1, 2016 states, in relevant part:

   > 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 … **With <u>most</u> "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** [emphasis added]**.** This E&M service may be related to the same diagnosis necessitating the 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** [emphasis added].

   Review of the submitted documentation finds that the requestor appended modifier -25, however did not document a significant, separately identifiable evaluation and management service. As a result, the DWC finds that the insurance carrier's denial reason is supported. Reimbursement for CPT Code 99214-25 cannot be recommended.

5. The insurance carrier denied HCPCs code A4556 with claim adjustment reason codes 00576, 234 and W3.

   The division finds that HCPCs code A4556 is a Bundled/Excluded code, which means:

   > There are no RVUs and no payment amounts for these services. No separate payment should be 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 physician service.)--If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (i.e., colostomy supplies) and should be paid under the other payment provision of the Act.

   The Medicare Benefit Policy Manual, Chapter 15 §60.1 states, "Incident to a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness." The services are incident to the physician services furnished the same day; and are considered bundled into those services. The DWC finds that the insurance carrier's denial is supported and therefore, reimbursement for this service cannot be 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 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 10, 2020 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 TAC §133.307, effective May 31, 2012, *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 MDR 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812