MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
DONALD MCPHAUL, MD

Respondent Name
LM INSURANCE CO

MFDR Tracking Number
M4-20-2138-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
MAY 4, 2020

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: $1111.48

RESPONDENT'S POSITION SUMMARY

"99204-25 denied as OFFICE VISIT/EVALUATION INCLUDED IN THE VALUE OF ANOTHER PROCEDURE…A4556 [electrodes] and A4215 [needle] these supplies are included in the value of the maximum allowable reimbursement allowance for office based procedures…95886x1 and 95912 denied level of service as only Left Upper Extremity EMG was authorized…95886x1 not paid as this is an add-on code and cannot be paid without the primary procedure code."
Response Submitted By: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 13, 2020	CPT Code 99204-25 New Patient Office Visit	$284.15	$0.00
	CPT Code 95886 (X2) Needle EMG	$338.38	$338.38
	CPT Code 95912 Nerve Conduction Studies	$457.05	$457.05
	HCPCS Code A4556 Electrodes	$16.90	$0.00
	HCPCS Code A4215 Needles	$15.00	$0.00
TOTAL		$1111.48	$795.43

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 (TAC) §133.307, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The respondent reduced / denied reimbursement for the disputed services based upon the following claim adjustment reason codes:

- 48-The provider billed for a visit on the same day of surgery or within the follow-up of a previously performed surgery.
- 275-The charge was disallowed; as the submitted report does not substantiate the service being billed.
- 292-This procedure code is only reimbursed when billed with the appropriate initial base code.
- X598-Claim has been re-evaluated based on additional documentation submitted; no additional payment due.
- 97-Payment is included in the allowance for another service/procedure.
- 243-The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
- W3-Additional payment made on appeal/reconsideration.

Issues

Is the requestor entitled to reimbursement for the disputed services rendered on February 13, 2020?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $1111.48 for CPT codes 99204-25, 95886, 95912, A4556 and A4215 rendered on February 13, 2020.
2. The fee guidelines for disputed services are found in 28 TAC §134.203.

   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."
3. 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 respondent denied reimbursement for CPT code 99204-25 based upon "48-The provider billed for a visit on the same day of surgery or within the follow-up of a previously performed surgery," and "97-Payment is included in the allowance for another service/procedure."

On the disputed date of service, the requestor billed for CPT code 99204-25, 95912, and 95886. Per 28 TAC §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, 2020, 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…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…
>
> 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 performed on the same date of service as a 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. NCCI contains many, but not all, possible edits based on these principles…
>
> 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.”

A review of the submitted report does not support “a significant, separately identifiable E/M service above and beyond the other service provided,” and “documentation that satisfies the relevant criteria for the respective E/M service to be reported.” The DWC finds the requestor’s documentation does not support one of the required 3 key components for code 99204, specifically the medical decision making component. The interpretation of the EMG/NCV is the professional component of those procedures and cannot be counted as a key component of code 99204; therefore, reimbursement is not recommended.

4. CPT Code 95912 is described as “Nerve conduction studies; 11-12 studies.”

   The respondent denied reimbursement for CPT code 95912 based upon “275-The charge was disallowed; as the submitted report does not substantiate the service being billed.”

   CPT coding guidelines for 95912 are:

   > For the purposes of coding, a single conduction study is defined as a sensory conduction test, a motor conduction test with or without an F wave test, or an H-reflex test. Each type of study (sensory, motor with or without F wave, H-reflex) for each nerve includes all orthodromic and antidromic impulses associated with that nerve and constitutes a distinct study when determining the number of studies in each grouping (eg, 1-2 or 3-4 nerve conduction studies). Each type of nerve conduction study is counted only once when multiple sites on the same nerve are stimulated or recorded. The numbers of these separate tests should be added to determine which code to use.

   The submitted report supports billed service; therefore, reimbursement is recommended.

   Per 28 TAC §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 2020 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 Houston, Texas.
   The Medicare participating amount for code 95912 in Houston, Texas is $273.68.
   Using the above formula, the MAR is $457.43 or less. The requestor is seeking $457.05. The respondent paid $0.00. The DWC finds the requestor is due $457.05.

5. CPT code 95886 is described as “Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure).” The requestor billed for two (2) units.

The respondent denied reimbursement for CPT code 95886(X2) based upon “275-The charge was disallowed; as the submitted report does not substantiate the service being billed.”

The National Correct Coding Initiative Policy Manual, effective January 1, 2020, Chapter I, General Correct Coding Policies, section (R) titled Add-On Codes states:

> Some codes in the "CPT Manual" are identified as “add-on” codes (AOCs), which describe a service that can only be reported in addition to a primary procedure. "CPT Manual" instructions specify the primary procedure code(s) for most AOCs. For other AOCs, the primary procedure code(s) is (are) not specified. When the "CPT Manual" identifies specific primary codes, the AOCs shall not be reported as a supplemental service for other HCPCS/CPT codes not listed as a primary code. AOCs permit the reporting of significant supplemental services commonly performed in addition to the primary procedure.

Per Publication 100-04, Medicare Claims Processing, Transmittal 2636, Change Request 7501, effective January 16, 2013:

> An add-on code is a HCPCS/CPT code that describes a service that is always performed in conjunction with another primary service. An add-on code is eligible for payment only if it is reported with an appropriate primary procedure performed by the same practitioner…Add-on codes may be identified in three ways:
>
> (1) The code is listed in this CR or subsequent ones as a Type I, Type II, or Type III, add-on code.
>
> (2) On the Medicare Physician Fee Schedule Database an add-on code generally has a global surgery period of "ZZZ".
>
> (3) In the *CPT Manual* an add-on code is designated by the symbol "**+**". The code descriptor of an add-on code generally includes phrases such as "each additional" or "(List separately in addition to primary procedure)."
>
> CMS has divided the add-on codes into three Groups to distinguish the payment policy for each group.
>
> Type I - A Type I add-on code has a limited number of identifiable primary procedure codes. The CR lists the Type I add-on codes with their acceptable primary procedure codes. A Type I add-on code, with one exception, is eligible for payment if one of the listed primary procedure codes is also eligible for payment to the same practitioner for the same patient on the same date of service. Claims processing contractors must adopt edits to assure that Type I add-on codes are never paid unless a listed primary procedure code is also paid.

As stated above, the primary procedure CPT code 95912 was supported and reimbursement was recommended.

Per Publication 100-04, Medicare Claims Processing, Transmittal 2636, Change Request 7501, effective January 16, 2013, CPT code 95886 is classified as a Type I code. Therefore, the above referenced guidelines apply. Based upon this guideline, CPT code 95886 is eligible for reimbursement.

The Medicare participating amount for code 95886 in Houston, Texas is $101.31.

Per 28 TAC §134.203(c)(1)(2) and above referenced formula the MAR is $169.33 or less X 2 units = $338.66 or less. The requestor is seeking $338.38. The respondent paid $0.00. The DWC finds the requestor is due $338.38.

6. HCPCS code A4556 is described as “Electrodes (e.g., apnea monitor), per pair.”

   The respondent denied reimbursement based upon “243-The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.”

   Per Medicare physicians’ fee schedule, HCPCS 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.

7. HCPCS code A4215 is described as "Needle, sterile, any size, each."

   The respondent denied reimbursement for HCPCS code A4215 based upon "243-The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed."

   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 95912. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $795.43.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services.
The DWC hereby ORDERS the respondent to remit to the requestor $795.43, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

______________________________	______________________________	05/21/2020
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.