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**
Donald McPhaul MD

**Respondent Name**
Indemnity Insurance Company

**MFDR Tracking Number**
M4-20-2166-01

**Carrier's Austin Representative**
Box Number 15

**MFDR Date Received**
May 4, 2020

**Response Submitted by:**
No response received

## *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 … Please note that an office consultation/examination was performed and documented separately on this date of service and billed accordingly with the appropriate modifier and should not be bundled or compounded per the CPT Codes as applied to this date of service. 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*

The Austin carrier representative for Indemnity Insurance Company is Downs & Stanford, PC. Downs & Stanford, PC was notified of this medical fee dispute on May 12, 2020. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| August 6, 2019 | Evaluation & Management, new patient (99204-25) | $274.14 | $0.00 |
| August 6, 2019 | Needle Electromyography, each extremity (95886) | $319.87 | $319.87 |
| August 6, 2019 | Nerve Conduction Studies, 9-10 studies (95911) | $0.00 | $0.00 |
| August 6, 2019 | Electrodes, per pair (A4556) | $16.90 | $0.00 |
| August 6, 2019 | Needle, sterile, any size, each (A4215) | $12.81 | $0.00 |
| TOTAL | | $623.72 | $319.87 |

## *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:
   - B12 – Services not documented in patients' medical records
   - P12 – Workers Compensation jurisdictional fee schedule adjustment
   - V318 – A recommendation cannot be determined as the medical record does not support an Evaluation and Management service at any level
   - PNFC – The reimbursement is based on the CMS Physician Fee Schedule Non-Facility site of service rate
   - 197 – Precertification/authorization/notification/pre-treatment absent
   - XF08 – Per the TX HCN and in accordance with TIC 1305. Pre-auth is required, if services have been pre-authorized or submit the bill with authorization info for reconsideration
   - 234 – This procedure is not paid separately
   - MSCP – In accordance with the CMS Physician Fee Schedule rule for status code P. This service is not separately reimbursed when billed with other payable services
   - P5 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement
   - P301 – The amount paid reflects the reasonable and customary charge

**Issues**

1. What are the services in dispute?
2. What are the applicable rules for the disputed services?
3. Is the insurance carrier's denial reason for HCPCs code A4215 supported?
4. Is the insurance carrier's denial reason for CPT code 99204-25 supported?
5. Is the insurance carrier's denial reason for HCPCs code A4556 supported?
6. Is the insurance carrier's denial reason for CPT code 95886 supported?
7. Is the requestor entitled to reimbursement for CPT Code 95886?

**Findings**

1. The requestor billed for CPT /HCPC codes 99204-25, 95886, 95911, A4556, and A4215 on August 6, 2019. The DWC060 Table of Dispute Services identifies that the requestor is not seeking reimbursement for CPT Code 95911. Therefore, this service will not be considered in this dispute. The requestor seeks reimbursement in the amount of $623.72 for procedure codes 99204-25, 95886, A4556, and A4215. These services will be reviewed in accordance with the 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 August 6, 2019. The insurance carrier reduced the disputed code with reductions codes, "P301 – The amount paid reflects the reasonable and customary charge" and "P5 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement." The disputed service is reviewed pursuant to 28 TAC §134.203 (b)(1) to determine if reimbursement is due.

   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 99204-25 with claim adjustment reason codes, "B12, P12, V318 and PNFC" (descriptions provided above).

   The DWC finds that the requestor billed CPT Codes 95911 and 99204-25 on the same date of service. Service Code 95911, 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 99204-25 cannot be recommended.

5. The insurance carrier denied HCPCs code A4556 with claim adjustment reason codes "234 and MSCP" (description provided above.)

   The DWC 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.

6. The insurance carrier denied CPT Code 95886 with claim adjustment reason codes, "197 and XFO6." The American Medical Association Current Procedural Terminology (CPT) defines code 95886 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)."

   Per 28 Texas Administrative Code §134.600(p)(8)(A-B) the non-emergency healthcare that requires preauthorization includes: "(8) unless otherwise specified in this subsection, a repeat individual diagnostic study: (A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline; or (B) without a reimbursement rate established in the current Medical Fee Guideline."

   The DWC finds that the insurance carrier did not respond to the DWC060 request, and therefore no documentation was submitted to support the denial of the disputed services. The DWC finds no evidence that the disputed NCV/EMG were repeat tests; therefore, the respondent's denial of payment based upon a lack of authorization is not supported.

   To determine if the requestor is due additional reimbursement for CPT code 95886 the Division refers to 28 Texas Administrative Code §134.203(c)(1)(2), which states "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 75247, which is in Dallas, Texas; therefore, the Medicare participating amount is based on locality "Dallas, Texas".

   The 2019 DWC conversion factor for this service is 59.19.

   The Medicare conversion factor is 36.0391.

   The Medicare participating amount for code 95886 in Dallas, TX is $97.52.

   Using the above formula, the Division finds the MAR is $320.33 for 95886. The requestor seeks $319.87. The respondent paid $0.00. The requestor is therefore due the lesser of $319.87.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $319.87.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of TLC Sections 413.031 and 413.019 (if applicable), the DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of $319.87 plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | June 30, 2020<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 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