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
AHMED KHALIFA, MD

Respondent Name
OHIO SECURTIY INSURANCE CO

MFDR Tracking Number
M4-21-2035-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
JULY 13, 2021

REQUESTOR'S POSITION SUMMARY

"DESIGNATED DOCTOR REFERRED TESTING INCORRECT REDUCTION…The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: $587.24

RESPONDENT'S POSITION SUMMARY

"No significant separately, identifiable Evaluation and Management service has been documented…CPT 95911 is for Nerve conduction studies; 9 10 studies; Only 5 NCS (CPT 95909) supported as the right side is not part of accepted injury."

Response Submitted By: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 17, 2020	CPT Code 99214-25 Established Patient Office Visit	$187.98	$0.00
	CPT Code 95911 Nerve Conduction Studies	$399.26	$399.26
TOTAL		$587.24	$399.26

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 February 22, 2021, 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:
4. The services in dispute were reduced / denied by the respondent with the following reason code:
   - 5845-No significant identifiable Evaluation and Management service is documented.
   - 275-The charge was disallowed; as the submitted report does not substantiate the service being billed.

Issues

Is the requestor entitled to additional reimbursement for the disputed services rendered on December 17, 2020?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $587.24 for CPT codes 99214-25, and 95911 rendered on December 17, 2020.
2. The respondent denied reimbursement for CPT code 99204-25 based upon "5845-No significant identifiable Evaluation and Management service is documented."

   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."

   CPT code 99214 is described as "office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history, a detailed examination and medical decision making of moderate complexity."

   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."

   On the disputed date of service, the requestor billed for CPT code 99214-25 and 95911. Per 28 TAC §134.203(a)(5), the DWC referred to Medicare's coding and billing policies. Per Medicare policies, CPT code 95911 has a global surgery period of "XXX.

   The National Correct Coding Initiative Policy Manual, effective January 1, 2020, Chapter I, General Correct Coding Policies, section D, states in part:

   > 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." Per Medicare policy any work for CPT code 99214 cannot include any work for code 95911.

Per MLN Matters, a detailed history must include, a chief complaint, and extended history of present illness, an extended review of systems (ROS) and a pertinent past, family and social history (PFSH) . A pertinent PFSH must document at least one item from any of the three history areas. A review of the submitted documentation did not include one item from the family history.

Per MLN Matters, a single organ system detailed exam must include, "Examinations other than the eye and psychiatric examinations should include performance and documentation of at least twelve elements identified by a bullet, whether in a box with a shaded or unshaded border." A review of the report did not sufficiently support the twelve elements identified by a bullet.

A review of the submitted report does not support two of the three key required components;" therefore, reimbursement is not recommended.

3. The respondent denied reimbursement for CPT code 95911 based upon "275-The charge was disallowed; as the submitted report does not substantiate the service being billed."

   CPT code 95911 is described as a study of 9-10 nerves. A review of the submitted report supports 10 nerves studies; therefore, the respondent's denial based upon "275" is not supported.

   The respondent wrote in the position summary, "Only 5 NCS (CPT 95909) supported as the right side is not part of accepted injury."

   28 TAC §133.307(d)(2)(F) states, "The responses 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." A review of the submitted EOBs does not support the denial based upon compensability or extent.

   28 TAC §133.307(d)(2)(H) states, "If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier must attach any related Plain Language Notice in accordance with §124.2 of this title (concerning Insurance Carrier Reporting and Notification Requirements)."

   The DWC finds the respondent did not submit a copy of the Plain Language Notice in accordance with §124.2 to support the denial based upon unrelated to work injury; therefore, the respondent's position regarding the right side is not part of accepted injury is not supported.

   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 60.32.

The Medicare Conversion Factor is 36.0896

Review of Box 32 on the CMS-1500 the services were rendered in Houston, Texas.

The Medicare participating amount for code 95911 in Houston , Texas is $239.08.

Using the above formula, the MAR is $399.60 or less. The requestor is seeking $399.26. The respondent paid $0.00. As a result, reimbursement of $399.26 is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $399.26.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $399.26, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		8/2/2021
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.