



**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**

FARMERS INSURANCE EXCHANGE

**MFDR Tracking Number**

M4-21-2037-01

**Carrier's Austin Representative**

Box Number 14

**MFDR Date Received**

JULY 13, 2021

**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:** \$298.86

**RESPONDENT'S POSITION SUMMARY**

"Carrier properly calculated reimbursement in this case and stands by the reasons for reduction of payment et forth in its Explanation of Benefits previously filed in this dispute."

**Response Submitted By:** Stone Loughlin Swanson

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 17, 2020	CPT Code 99204-25 New Patient Office Visit	\$284.15	\$0.00
	CPT Code 95886 (X2) Needle EMG	\$0.00	\$0.00
	CPT Code 95913 Nerve Conduction Studies	\$0.00	\$0.00
	HCPCS Code A4556 Electrodes	\$0.00	\$0.00
	HCPCS Code A4215 Needles	\$14.71	\$0.00
TOTAL		\$298.86	\$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 (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 services in dispute were reduced / denied by the respondent with the following reason code:
  - 95-Plan procedure not followed.
  - U00- There was no UR procedure/treatment requested/received.
  - U04-The billed service exceeds the UR amount authorized.
  - P12-Workers' compensation jurisdictional fee schedule adjustment.
  - 16-Claim/service lacks documentation or has submission billing/errors
  - U03-The billed service was reviewed by UR and authorized.
  - 205-This charge was disallowed as additional information/definition is required to clarify service/supply rendered.
  - W3-In accordance with rule 134.804, this bill has been identified as a request for reconsideration or appeal.
  - 350-Bill has been identified as a request for reconsideration or appeal.
  - 790-The charge was reimbursed in accordance to the Texas medical fee guideline.

### **Issues**

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

### **Findings**

1. The requestor is seeking medical fee dispute resolution in the amount of \$298.86 for CPT codes 99204-25, and HCPCS code A4215 rendered on November 17, 2020.
2. The respondent denied reimbursement for CPT code 99204-25 based upon "16-Claim/service lacks documentation or has submission billing/errors," and "205-This charge was disallowed as additional information/definition is required to clarify service/supply rendered."
3. 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 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.”

On the disputed date of service, the requestor billed for CPT code 99204-25, 95913, 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 95913 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 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. The requestor is seeking medical dispute resolution for \$14.71 for HCPCS code A4215.

HCPCS code A4215 is defined as "Needle, sterile, any size, each." The respondent issued reimbursement of \$0.29 based upon the fee guideline.

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 95913. As a result, additional reimbursement is not recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due.

### ***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 reimbursement for the disputed services.

### **Authorized Signature**

_____	_____	8/10/2021
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.**