



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Donald McPhaul, MD

Respondent Name

Arch Insurance Co.

MFDR Tracking Number

M4-21-2349-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

August 18, 2021

Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|------------------|-------------------|-------------------|---------------|
| March 4, 2021 | CPT Code 99204-25 | \$297.89 | \$0.00 |
| | CPT Code 95886 | \$0.00 | \$0.00 |
| | CPT Code 95913 | \$0.00 | \$0.00 |
| | HCPCS Code A4556 | \$16.90 | \$0.00 |
| | HCPCS Code A4215 | \$14.71 | \$0.00 |
| Total | | \$329.50 | \$0.00 |

Requestor's Position

"The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: \$329.50

Respondent's Position

August 27, 2021: "Supplemental response will be provided once the bill auditing company has finalized their review."

September 16 2021: "Our CV team has determined that the provider is not due any additional allowance for the disputed denial."

Response Submitted by: Gallagher Bassett Services

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system_

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- P12-Workers' compensation jurisdictional fee schedule adjustment.
- 97-Payment adjusted because the benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 00663-Reimbursement has been calculated according to state fee schedule guidelines.
- 168-Payment denied as service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.
- 150-Payment adjusted because the payer deems the information submitted does not support this level of service.
- 5352-Service reduced/denied as Level of E&M code submitted is not supported by documentation.
- 56-Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by the payer.
- 223-Adjustment code for mandated federal, state or local law regulation that is not already covered by another code and is mandated before a new code can be created.
- 309-The charge for this procedure exceeds the fee schedule allowance.
- 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.

Issues

1. Is Arch Insurance Company's denial of CPT code 99204-25 based on information submitted does not support this level of service supported?
2. Is Arch Insurance Company's denial of HCPCS code A4556 based upon unbundling supported?
3. Is Arch Insurance Company's denial of HCPCS code A4215 based upon unbundling supported?

Findings

1. The fee guidelines for disputed services is 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."

The respondent denied reimbursement for CPT code 99204-25 based upon reason codes "150," "P12," and "5352." (listed above)

CPT code 99204 is described as "Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter."

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, 2021, 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. The NCCI program 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 high level medical decision making or

the time spent performing the evaluation. 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.

2. The requestor is seeking medical dispute resolution for \$16.90 for HCPCS code A4556.

The respondent denied reimbursement for HCPCS code A4556 based upon reason codes "97," and "243." (listed above)

HCPCS code A4556 is defined as "Electrodes (e.g., apnea monitor), per pair."

Per Medicare physicians' fee schedule, 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.

3. The requestor is seeking medical dispute resolution for \$14.71 for HCPCS code A4215.

The respondent paid \$0.29 for HCPCS code A4215 based upon reason code "P12," and "309." (listed above)

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

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

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

| | | |
|-----------|--|------------|
| _____ | _____ | 10/01/2021 |
| 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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico CompConnection@tdi.texas.gov.