TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Donald Martin McPhaul

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-21-2351-01

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
May 24, 2021	99204 25	$297.89	$0.00
May 24, 2021	95886	$0.00	$0.00
May 24, 2021	95913 [sic]	$0.00	$0.00
	Total	$297.89	$0.00

Requestor's Position

The Doctor had to perform the consult to verify that the patient was a candidate for the EMG/NCV study. This is why a comprehensive medical history, comprehensive examination (RDM) etc., and moderate complexity decision making are included in the report. Because, those components are not required for the study. This is why modifier 25 is added to the consult.

Amount in Dispute: $297.89

Respondent's Position

In summary, the Requester is not entitled to any reimbursement under code 99204.25 because there was no separate comprehensive history, exam or medical decision making that was not inherent in the related procedure therefore the submitted billing is not in accordance with Medicare and DWC policies.

Response Submitted by: Stephen J. Backhaus, PLLC

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 TAC §133.307 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

Denial Reasons

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

- 150 – Payment adjusted because the payer deems the information submitted does not support this level of service.
- P12 – Workers' Compensation Jurisdictional fee schedule adjustment
- 5405 – This charge was reviewed through the clinical validation program
- 193 – Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly

Issues

1. Is the insurance carrier's denial based on information does not support the level of service supported?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $297.89 for CPT code 99204-25 for date of service May 24, 2021.

   The fee guidelines for disputed service 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."

   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 moderate level of medical decision making. When using time for code selection, 45-59 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."

The respondent denied reimbursement for CPT code 99204-25 as unsupported level of service. Review of the submitted medical record found time in to be 9:40 am and time out 10:52 am. However, during this time the record indicates the EMG/NCV testing was also done. Insufficient evidence was found to support how much time was spent conducting the consultation separately from the testing. Additionally, the medical decision making required for this code is moderate. Review of the submitted medical record found the medical decision was low. The respondent's denial is supported. As a result, 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

		September 22, 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 electronico CompConnection@tdi.texas.gov.