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 M. MCPHAUL

Respondent Name
AMERICAN ZURICH INSURANCE CO.

MFDR Tracking Number
M4-21-2361-01

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 12, 2021	99204-25, 95886 and 95912	$1,088.53	$802.60
	Total	$1,088.53	$802.60

Requestor's Position

"Work Comp Treatment and Services no Payment Received."

Amount in Dispute: $1,088.53

Respondent's Position

"The carrier filed two EOBs dated May 18, 2021 and July 12, 2021. The denials on both of them was "based on entitlement to benefits," meaning that the claim has been denied. Before a case can proceed through the medical fee dispute resolution process, any dispute concerning the denial of the claim must be resolved at the hearings level."

Response Submitted by: Flahive, Ogden & Latson

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 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §124.2, sets out the insurance carrier reporting and notification requirements.

Denial Reasons

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

- P6 – Based on entitlement to benefits
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. Are there unresolved issues regarding liability for the injury?
2. Is the requestor entitled to reimbursement for CPT Code 99204-25?
3. Is the requestor entitled to reimbursement for CPT Code 95912?
4. Is the requestor entitled t reimbursement for CPT Code 95886?

Findings

1. The requestor seeks reimbursement for CPT Codes 99204-25, 95886 and 95912 rendered on May 12, 2021. The insurance carrier denied payment for the disputed compound with claim adjustment reason code "P6."

   Review of the submitted information finds no copies, as required by Rule $133.307(d)(2)(H), of any PLN-11 or plain language notices issued in accordance with Rule §124.2.

   Rule §124.2(h) requires notification to the division and claimant of any dispute of disability or extent of injury using plain language notices with language and content prescribed by the division. Such notices "shall provide a full and complete statement describing the carrier's action and its reason(s) for such action. The statement must contain sufficient claim-specific substantive information to enable the employee/legal beneficiary to understand the carrier's position or action taken on the claim."

Rule §133.307(d)(2)(H) further requires that if the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with Rule §124.2 (relating to carrier reporting and notification requirements).

The insurance carrier's denial reason is therefore not supported. Furthermore, because the respondent failed to meet the requirements of Rule §133.307(d)(2)(H) regarding notice of issues of liability, the respondent has waived the right to raise such issues during dispute resolution. Consequently, the division concludes there are no outstanding issues of compensability or liability for the injury.

2. The requestor seeks reimbursement for CPT Codes 99204-25 rendered on May 12, 2021.

   28 Texas Administrative Code §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."

   The respondent denied reimbursement for CPT code 99204-25 based upon "48-The provider billed for a visit on the same day of surgery or within the follow-up of a previously performed surgery," and "97-Payment is included in the allowance for another service/procedure."

On the disputed date of service, the requestor billed for CPT code 99204-25, 95912, 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 95912 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 one of 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.

3. The requestor seeks reimbursement for CPT Code 95912 rendered on May 12, 2021.

CPT Code 95912 is described as "Nerve conduction studies; 11-12 studies."

CPT coding guidelines for 95912 are:

> For the purposes of coding, a single conduction study is defined as a sensory conduction test, a motor conduction test with or without an F wave test, or an H-reflex test. Each type of study (sensory, motor with or without F wave, H-reflex) for each nerve includes all orthodromic and antidromic impulses associated with that nerve and constitutes a distinct study when determining the number of studies in each grouping (eg, 1-2 or 3-4 nerve conduction studies). Each type of nerve conduction study is counted only once when multiple sites on the same nerve are stimulated or recorded. The numbers of these separate tests should be added to determine which code to use.

The submitted report supports billed service; therefore, reimbursement is recommended.

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 2021 DWC conversion factor for this service is 61.17.
- The Medicare Conversion Factor is 34.8931
- Review of Box 32 on the CMS-1500 the services were rendered in Waco, Texas.
- The Medicare participating amount for code 95912 in Waco, Texas is $257.69.

Using the above formula, the MAR is $451.75 or less. The requestor is seeking $450.96. The respondent paid $0.00. The DWC finds the requestor is due $450.96.

4. The requestor seeks reimbursement for CPT code 95886 rendered on May 12, 2021.

CPT Code 95886 is described 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)." The requestor billed for two (2) units.

The National Correct Coding Initiative Policy Manual, effective January 1, 2020, Chapter I, General Correct Coding Policies, section (R) titled Add-On Codes states:

> Some codes in the "CPT Manual" are identified as "add-on" codes (AOCs), which describe a service that can only be reported in addition to a primary procedure. "CPT Manual" instructions specify the primary procedure code(s) for most AOCs. For other AOCs, the primary procedure code(s) is (are) not specified. When the "CPT Manual" identifies specific primary codes, the AOCs shall not be reported as a supplemental service for other HCPCS/CPT codes not listed as a primary code. AOCs permit the reporting of significant supplemental services commonly performed in addition to the primary procedure.

Per Publication 100-04, Medicare Claims Processing, Transmittal 2636, Change Request 7501, effective January 16, 2013:

> An add-on code is a HCPCS/CPT code that describes a service that is always performed in conjunction with another primary service. An add-on code is eligible for payment only if it is reported with an appropriate primary procedure performed by the same practitioner…Add-on codes may be identified in three ways:

(1) The code is listed in this CR or subsequent ones as a Type I, Type II, or Type III, add-on code.

(2) On the Medicare Physician Fee Schedule Database an add-on code generally has a global surgery period of "ZZZ".

(3) In the CPT Manual an add-on code is designated by the symbol "+". The code descriptor of an add-on code generally includes phrases such as "each additional" or "(List separately in addition to primary procedure)."

CMS has divided the add-on codes into three Groups to distinguish the payment policy for each group.

Type I - A Type I add-on code has a limited number of identifiable primary procedure codes. The CR lists the Type I add-on codes with their acceptable primary procedure codes. A Type I add-on code, with one exception, is eligible for payment if one of the listed primary procedure codes is also eligible for payment to the same practitioner for the same patient on the same date of service. Claims processing contractors must adopt edits to assure that Type I add-on codes are never paid unless a listed primary procedure code is also paid.

As stated above, the primary procedure CPT code 95912 was supported, and reimbursement was recommended.

Per Publication 100-04, Medicare Claims Processing, Transmittal 2636, Change Request 7501, effective January 16, 2013, CPT code 95886 is classified as a Type I code. Therefore, the above referenced guidelines apply. Based upon this guideline, CPT code 95886 is eligible for reimbursement.

- The Medicare participating amount for code 95886 in Waco, Texas is $100.47.
- Per 28 TAC §134.203(c)(1)(2) and above referenced formula the MAR is $176.13 or less X 2 units = $352.26 or less.

The requestor is seeking $351.64. The respondent paid $0.00. The DWC finds the requestor is due $351.64.

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 established that reimbursement in the amount $802.60 is due.

Order

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requestor $802.60, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		September 28, 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.