Division of Workers' Compensation

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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
JAMES DANA WEISS, MD

Respondent Name
LIBERTY INSURANCE CORPORATION

MFDR Tracking Number
M4-23-0197-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
September 23, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 23, 2021	99204, 95886 (2) and 95911	$1,095.03	$790.37
	Total	$1,095.03	$790.37

Requestor's Position

"DESIGNATED DR REFERRED TESTING NO PAYMENT RECEIVED."

Amount in Dispute: $1,095.03

Respondent's Position

"99204 Denied as this is not for a separate issue from the testing… Code 95911 is denied as this level of service is not documented, The compensable body part is the left upper extremity, Testing for the compensable body part would be appropriate, There is no UM authorization indicating a need for the right-side testing, therefore the compensable side is payable, There are not 9-10 nerves tested on the left upper extremity. Codes 95886 x 2 are denied as this code is an add on code and only payable with a primary paying code. Since 95911 is denied, 95886 cannot be paid. The 95886 for the right side would not be payable as this was to a non-compensable body part."

Response Submitted by: Liberty Mutual Insurance

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 sets out the fee guideline for professional medical services.

Denial Reasons

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

- 63 – The evaluation and management visit is not beyond the usual pre/post service.
- 292 – This procedure code is only reimbursed when billed with the appropriate base code.
- 943 – Documentation does not support billed charge. No recommendation of payment can be made.

Issues

1. Does the documentation support billing CPT codes 99204, 95886 (2) and 95911?
2. Is the requestor entitled to reimbursement for the services in dispute?

Findings

1. The requestor seeks reimbursement for CPT Codes 99204, 95886 (2) and 95911 rendered on September 23, 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 defined 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 respondent denied reimbursement for CPT code 99204 based upon "63 – The evaluation and management visit is not beyond the usual pre/post service."

   On the disputed date of service, the requestor billed for CPT code 99204, 95911, 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 95911 has "XXX".

The National Correct Coding Initiative Policy Manual, effective January 1, 2016, 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. The global period for YYY procedures is defined by the Carrier (A/B MAC processing practitioner service claims). 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, intraprocedural, 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 that the requestor did not support the billing of CPT Code 99204 in conjunction with CPT codes 95886 and 95911. Therefore, the DWC finds that the requestor's is not entitled to reimbursement for CPT Code 99204.

2. Rule §134.203 applies to CPT Codes 95886 and 95911.

   CPT Code 95911 is described as "Nerve conduction studies; 9-10 studies."

   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).

   28 TAC §134.203(b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   Review of the submitted documentation supports the billing of CPT codes 95911 and 95886. As a result, the requestor is entitled to reimbursement for these charges.

   28 TAC §134.203 states in pertinent part, "(c) 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..."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

   - The 2021 DWC Conversion Factor is 61.17
   - The 2021 Medicare Conversion Factor is 34.8931
   - Per the medical bills, the services were rendered in zip code 77042; therefore, the Medicare locality is "Houston."

The Medicare Participating amount for CPT code 95911 at this locality is $237.10.

- Using the above formula, the DWC finds the MAR is $415.65.
- The respondent paid $0.00.
- The requestor seeks $414.93, as a result this amount is recommended.

The Medicare Participating amount for CPT Code 95886 at this locality is $107.27

- Using the above formula, the DWC finds the MAR is $188.05 x 2 units = $376.10.
- The respondent paid $0.00.
- The requestor seeks $375.44, as a result this amount is 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.

The DWC finds the requester has established that reimbursement of $790.37 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor $790.37 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		January 23, 2023
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.