TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Kyle E. Jones, M.D.

Respondent Name
ZNAT Insurance Co.

MFDR Tracking Number
M4-23-0287-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
September 30, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 30, 2022	New Patient Examination 99203-25	$203.41	$0.00

Requestor's Position

"An E/M service was necessary to assess for nerve, bone, tendon damage and blood supply, as well as review of systems, past medical/surgical/family and social history, as she was a new patient."

Amount in Dispute: $203.41

Respondent's Position

"The disputed code 99203-25 … was billed in combination with CPT code 12034 … that has a global period '010 days' … The submitted documentation does not present a significant and separately identifiable E/M service unrealtated to the laceration repair. E/M work does not go above and beyond the work associated with the minor surgical procedure 12034. Therefore the E/M service … would be considered included in the payment for CPT code 12034 as a 'new' patient visit does not justify reporting an E/M service with the minor surgical procedure code."

Response Submitted by: The Zenith

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.203 sets out the fee guidelines for professional medical services.

Denial Reasons

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

- 217 – The value of this procedure is included in the value of another procedure performed on this date.
- 97 – The benefit for this service is included in the payment/allowance for another service/proceduire that has already been adjudicated.
- Notes: "99203 INCLUSIVE TO12034."
- Notes: "UPON FURTHER REVIEW, NO ADDITIONAL ALLOWANCE IS RECOMMENDED. 99203 INCLUSIVE TO 12034"

Issues

1. Is the insurance carrier's denial of payment supported?

Findings

1. Kyle E. Jones, M.D. is seeking reimbursement for procedure code 99203-25. The insurance carrier denied payment stating, the "value of this procedure is included in the value of another procedure performed on this date."

   Procedure code 99203 is defined 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 low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter."

   Dr. Jones billed this code with the same date of service as procedure code 12034, which is defined as "Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 7.6 cm to 12.5 cm." According to the Medicare Physician Fee Schedule, this procedure has a global period indicator of 010. The Medicare Physician Fee Schedule Guide indicates that 010 indicates that the service is a "minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day

postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable."

Per 28 TAC §134.203(b), "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.

Per the General Correct Coding Policies For Medicare National Correct Coding Initiative Policy Manual, Chapter 1, Section D, "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/supplier 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."

Section E.b. further states, "The 'CPT Manual' defines modifier 25 as a '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.' Modifier 25 may be appended to an evaluation and management (E&M) CPT code to indicate that the E&M service is significant and separately identifiable from other services reported on the same date of service. The E&M service may be related to the same or different diagnosis as the other procedure(s).

"Modifier 25 may be appended to E&M services reported with minor surgical procedures (with global periods of 000 or 010 days) … Since minor surgical procedures … include pre-procedure, intra-procedure, and post-procedure work inherent in the procedure, the provider/supplier shall not report an E&M service for this work. Furthermore, Medicare Global Surgery Rules prevent the reporting of a separate E&M service for the work associated with the decision to perform a minor surgical procedure regardless of whether the patient is a new or established patient."

After review of the submitted documentation, DWC concludes that Dr. Jones did not sufficiently support that the examination in dispute met the requirements of a significant, separately identifiable evaluation and management service for the purposes of overriding the global pre-procedure edit. The insurance carrier's denial of payment is supported and no reimbursement 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.

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 entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 7, 2023 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 three 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 tres o correo electronico CompConnection@tdi.texas.gov.