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 MD

**Respondent Name**
LIBERTY MUTUAL CORPORATION

**MFDR Tracking Number**
M4-23-0865

**Carrier's Austin Representative**
Box Number 01

**DWC Date Received**
December 14, 2022

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| September 27, 2022 | 99205,95886, and 95912 | $1,193.99 | $808.29 |
| | **Total** | $1,193.99 | $808.29 |

## Requestor's Position

"DESIGNATED DR REFERRED TESTING NO PAYMENT RECEVIED."

Amount in Dispute: $1,193.99

### Respondent's Position

"On the original bill image, duplicate bill image, and appeal bill image the Requestor billed service codes 95912, 95886, 95886, and 99205-25 ... LM only finds that the accepted, reasonable, necessary treatment should have been performed to the left upper arm, Motor and Sensory nerves of Median, Ulnar, and Radial, 5 studies, not 12. The provider billed the incorrect code, 95912, for the accepted injury (left). The code the provider should have billed Is 95909 based on the accepted Injury site and recommended treatment site ... The two units of 95886 are supported but 95912 was denied. No payment was issued as the primary procedure, 95912, was denied. LM finds that the accepted, reasonable, necessary treatment is for the [injury] and payment could not issue based on CPT coding rules ... There was no service above and beyond

the pre, intra, post procedure to warrant the billing of 99205-25. All the service in the evaluation note is inherent to the electromyography and nerve conduction velocity, nothing performed was outside the standard workup prior to the procedure. Interpretation of the results for the electromyography and nerve conduction velocity is part of the payment of 95912, 95886."

**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 Texas Administrative Code (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.28 Texas Administrative Code §137.100 sets out provision of the treatment guidelines.

Denial Reasons

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

- 5845 -No significant identifiable evaluation and management service has been documented.
- 292 -This procedure code is only reimbursed when billed with the appropriate initial base code.
- 275 -The charge was disallowed as the submitted report does not substantiate the service being billed.
- 193 -Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. What is the definition of CPT Codes 99204-25, 95886 and 95912?

2. Is the Insurance Carrier's denial reason supported for CPT Code 99204-25?

3. Is the requester entitled to reimbursement for CPT Code 95912?

4. Is the requester entitled to reimbursement for CPT Code 95886?

5. Is the Requester entitled to reimbursement?

Findings

1. The requester seeks reimbursement for CPT Codes 99205-25, 95886 and 95912 rendered on September 27, 2022. The insurance carrier denied the disputed services with denial reduction codes indicated above.

   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."

   CPT code 99205 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 requester appended modifier -25 to CPT 99205.

   Modifier -25 is described as "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 is further described 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."

   CPT Code 95886 lay description is, "Needle electromyography (EMG) records the electrical properties of muscle using an oscilloscope. Recordings, which may be amplified and heard through a loudspeaker, are made during needle insertion, with the muscle at rest, and during contraction. Report 95885 per limited study of an extremity and 95886 for a complete (five or more muscles) study of an extremity. Codes 95885-95886 can be reported for a total of four units if all extremities are tested."

   CPT Code 95912 lay description is "Three types of nerve conduction studies are represented by these codes: sensory conduction, motor conduction (with or without an F wave test), or an H-reflex test. Electrodes are placed directly over the nerve, in sensory conduction testing, or over the motor point of a specific muscle in motor conduction testing. Electrical stimulation is applied. The latency, amplitude, and conduction velocity of the stimulation are measured. Adjustments to any of the testing elements (stimulus site, recording site, ground site, filtered settings) are made to minimize unintended stimulation of adjacent nerves. A report is

generated on site that interprets the numerous test results at each site tested. Each type of study is reported only once regardless of the number of times performed on the same nerve in different areas. Report 95907 for up to two studies; 95908 for three or four studies; 95909 for five or six studies; 95910 for seven or eight studies; 95911 for nine or 10 studies; 95912 for 11 or 12 studies; or 95913 for 13 or more studies."

2. On the disputed date of service, the requester billed for CPT code 99205-25, 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, 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 the requestor's documentation does not support one of the required key components for CPT 99205, specifically the medical decision-making (MOM) component. The interpretation of the EMG/NCV is the professional component of those procedures and cannot be counted as a key component of CPT 99205; therefore, reimbursement is not recommended for CPT 99205.

3. The respondent denied reimbursement for CPT code 95912. based upon "275-The charge was disallowed; as the submitted report does not substantiate the service being billed."

   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.

4. 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 requester billed for two (2) units. The respondent denied reimbursement for CPT code 95886 (x 2 units) based upon "292-This procedure code is only reimbursed when billed with the appropriate initial base code."

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 11, or Type Ill, 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 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.

5. 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 2022 DWC Conversion Factor is 62.46
- The 2022 Medicare Conversion Factor is 34.6062
- Per the medical bills, the services were rendered in zip code 79925; therefore, the
- Medicare locality is "Rest of Texas."

The Medicare Participating amount for CPT 95886 at this locality is $99.31.

- Using the above formula, the DWC finds the MAR is (62.46/34.6062) x $99.31 =$179.24 per unit. 2 units were billed so $179.24 x 2 units = $358.48.
- The respondent paid $0.00.
- Reimbursement of $358.48 is recommended.

The Medicare Participating amount for CPT 95912 at this locality is $249.22.

- Using the above formula, the DWC finds the MAR is (62.46/34.6062) x $249.22 = $449.81
- The respondent paid $0.00.
- Reimbursement of $449.81 is recommended.

The total MAR for the allowed procedures is $808.29.

## Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that respondent must remit to requestor $808.29 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

**Authorized Signature**

| Greg Arendt | Greg Arendt | July 20, 2023 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Director | 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.