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

General Information

Requestor Name
Cesar Pierre Duclair, M.D.

Respondent Name
LM Insurance Corp.

MFDR Tracking Number
M4-23-1881-01

Carrier's Austin Representative
Box Number 1

DWC Date Received
March 31, 2023

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
10/29/2022	99205	$403.92	$0.00
10/29/2022	95886	$0.00	$0.00
10/29/2022	95912	$0.00	$0.00
	Total	$403.92	$0.00

Requestor's Position

Texas Administrative Code (TAC)§133.307(c)(2)(N) sets out requirements of requester's position statement when requesting medical fee dispute resolution (MFDR) states in pertinent part "… a position statement of the disputed issue(s) that shall include: (i) the requestor's reasoning for why the disputed fees should be paid or refunded, (ii) how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues, and (iii) how the submitted documentation supports the requestor's position for each disputed fee issue… "

Requester's position statement, submitted by Genesis Medical Management Solutions, references CPT Code 99202 but does not reference the disputed service, CPT Code 99205. Therefore, the requester's position statement is not relevant to this dispute.

Amount in Dispute: $403.92

Respondent's Position

"… The Explanation of Payments (EOP) sent to the provider had denial message 5845 for Current Procedural Terminology (CPT) code 99205 with modifier 25. This denial (5845) stated, NO SIGNIFICANT IDENTIFIABLE EVALUATION AND MANAGEMENT SERVICE HAS BEEN DOCUMENTED.

The provider was advised on this denial four times. LM logic of denial for 99205-25 is based on usage of Medicare payment policy. According to Medicare payment policy of National Correct Coding Initiatives (NCCI) Chapter 11: CPT codes assigned Global Day Calculator or Follow Up Day of XXX have the distinction of the 'global concept does not apply to the code.' CPT code 95912 billed by the provider is an 'XXX' procedure. NCCI: 'Many of these 'XXX' procedures are performed by physicians have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work shall not be reported as a separate E & M code (99205). With most 'XXX' procedures, the physician may, however, perform a significant and separately identified E & M service that is above and beyond the usual pre-and post-operative work of the procedure on the same date of the service which may be reported by appending modifier 25 to the E & M code… but cannot include any work inherent in the 'XXX' procedure, ... or time for interpreting the result of the 'XXX' procedure.' LM found that all the service provided by the requestor on the date of service is inherent to the CPT code 95912. The interpretation of the EMG NCS results is included in the payment of 95912. The provider failed to support the usage of modifier 25 for CPT code 99205. The report submitted does not support any significant, separate, distinct service, above and beyond the pre, intra, post procedure work for 95912… "

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.
3. 28 TAC §133.210 sets out medical documentation requirements for reimbursement of medical services.

Denial Reasons

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

- 5845 – No significant identifiable evaluation and management service has been documented.
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

Issues

1. What rules apply to the disputed services?
2. Is the requestor entitled to reimbursement for CPT Code 99205?

Findings

Note that CPT Codes 95886 and 95912, were included on the DWC60 form and on the same bill with disputed service code 99205-25, have been reimbursed by the respondent and are not in dispute. Therefore, only 99205 will be addressed and adjudicated.

1. The dispute concerns an evaluation and management service billed under CPT code 99205. The division finds that 28 TAC §133.210(c)(1) applies to reimbursement of CPT code 99205.

   28 (TAC) §133.210(c)(1) sets out medical documentation requirements, stating in pertinent part "In addition to the documentation requirements of subsection (b) of this section, medical bills for the following services shall include the following supporting documentation: the two highest Evaluation and Management office visit codes for new and established patients: office visit notes/report satisfying the American Medical Association requirements for use of those CPT codes…" As CPT code 99205 is one of the two highest evaluation and management codes, the division finds that (TAC) §133.210(c)(1) required the requestor to submit supporting documentation to satisfy American Medical Association requirements.

   The division finds that 28 TAC §134.203(b)(1) applies to reimbursement of CPT code 99205.

   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."

2. The requestor is seeking reimbursement in the amount of $403.92 for CPT Code 99205 rendered on October 29, 2022.

   - CPT Code 99205 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 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 American Medical Association (AMA) CPT Code and Guideline Changes, effective January 1, 2021, can be found at: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf. In summary, CPT 99205 documentation must contain two out of three of the following elements: 1) high level of number and complexity of problems addressed 2) extensive level of amount and/or complexity of data to be reviewed and analyzed 3) high risk of morbidity/mortality of patient management OR must document 60-74 minutes of total time spent on the date of patient encounter.
   - An interactive Evaluation and Management (E&M) scoresheet tool is available at: https://www.novitas-solutions.com/webcenter/portal/MedicareJL/EMScoreSheet

     A review of submitted medical documentation finds that a high level of MDM was not met in the elements of 1) number and complexity of problems addressed 2) high risk of morbidity/mortality of patient management. The division finds no documentation of

time spent on E&M service in submitted medical record.

- Per CMS article, found at:

  Article - Billing and Coding: Nerve Conduction Studies and Electromyography (A57478) (cms.gov),

  "I. Coding Guidelines A.) Evaluation/Management (E/M) 1) Usually an E&M service is included in the exam performed just prior to and during nerve conduction studies and/or electromyography. If the E&M service is a separate and identifiable service, the medical record must document medical necessity and the CPT code must be bill with a modifier 25."

- The Division applies Medicare's coding and billing policies in accordance with 28 TAC §134.203 as indicated above. Per Medicare Fee Schedule, CPT code 95912 has a global period of XXX.

  According to National Correct Coding Initiative Policy Manual for Medicare Services, revised 5/1/2022, "… Many of these 'XXX' procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work shall not be reported as a separate E&M code… 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..."

  Review of submitted medical documentation finds that disputed CPT code 99205 rendered on October 29, 2022, was inherent to the performance of CPT code 95912 billed on same date. Submitted medical record does not support charge for a distinctly separate identifiable office visit.

- The division finds that the requester is not entitled to reimbursement for CPT code 99205 rendered on October 29, 2022.

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 Division finds the requester has not established that reimbursement is due.

ORDER

Under Texas Labor Code §§413.031, the Division has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		April 21, 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.