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
Arch Insurance Co.

MFDR Tracking Number
M4-23-1883-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
March 31, 2023

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
08/06/2022	99204	$305.91	$0.00
08/06/2022	95886	$0.00	$0.00
08/06/2022	95912	$0.00	$0.00
	Total	$305.91	$0.00

Requestor's Position

"… Please note that an office consultation/examination was performed and documented separately on this date of service and billed accordingly with the appropriate modifier… as you can see from the attached report an examination was performed and documented as a Detailed Examination component and billed as 99202. See report for all 6 elements required for a general multi-system examination. Per the attached documentation all components have been met for CPT Code 99202… We have attached the CMS documentation for Evaluation and Management Services that will show that all components are met in our documentation for CPT Code 99202… "
Amount in Dispute: $305.91

Respondent's Position

"…The provider billed a total of $1166.37. The provider acknowledged that he was paid $860.46. He is seeking an additional $305.91 based upon CPT code 99204. … The provider was not reimbursed for the office visit under CPT code 99204 because the documentation/report did not support the service billed. In other words, documentation did not support the reimbursement under CPT code 99204. Unless and until the provider submits sufficient

documentation to support the service under CPT code 99204, the provider is not entitled to any additional payment…"
Response Submitted by: Arch Insurance Co.

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:

- 275 – The charge was disallowed; as the submitted report does not substantiate the service being billed.
- 5524 – Charges not supported by documentation submitted for review. Please resubmit with correct documentation to support services being billed.
- 6766 – Specialty bill audit/ expert code review involving the application of code auditing rules and edits based on coding conventions defined in the…
- TXB12 – Services not documented in patients' medical records.

Issues

1. What rules apply to the disputed services?
2. Is the requestor entitled to reimbursement for CPT Code 99204?

Findings

Note that CPT Codes 95886 and 95912, were included on the DWC60 form and on the same bill with disputed service code 99204-25, have been reimbursed by the respondent and are not in dispute. Therefore, only 99204 will be addressed and adjudicated.

The division further notes that the requester's position statement refers to CPT code 99202, not the service in dispute. Thus, the requester's position statement will not be considered.

1. The dispute concerns an evaluation and management (E&M) service billed under CPT code 99204. The division finds that 28 TAC §133.210(c)(1) applies to reimbursement of CPT code 99204.

   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 99204 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 further finds that 28 TAC §134.203(b)(1) applies to reimbursement of CPT code 99204.

   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 $305.91 for CPT Code 99204 rendered on August 6, 2022.

   - CPT Code 99204 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 moderate level of medical decision making. When using time for code selection, 45-59 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 99204 documentation must contain two out of three of the following elements: 1) moderate level of number and complexity of problems addressed 2) moderate level of amount and/or complexity of data to be reviewed and analyzed 3) moderate risk of morbidity/mortality of patient management OR must document 45-59 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 moderate level of medical decision making was not met in the elements of 1) number and complexity of problems addressed 2) moderate level of amount and/or complexity of data to be reviewed and analyzed 3) moderate risk of morbidity/mortality of patient management. Submitted medical record shows 47 minutes of time spent on date of encounter included time spent performing and interpreting EMG/NCV diagnostic procedure. The division finds that the medical record does not support time spent on separate E&M service alone.

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 99204 rendered on August 6, 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 99204 rendered on August 6, 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

		May 1, 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.