Division of Workers' Compensation

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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Ellis County Associates

Respondent Name
Sentry Insurance A Mutual Co.

MFDR Tracking Number
M4-23-1904-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
April 3, 2023

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
10/12/2022	99202	$140.00	$0.00
	Total	$140.00	$0.00

Requestor's Position

"… We have received denials… stating our claims are denying per audit date 01/3 l/2023 due to 'an additional E/M visit code may be reported with modifier 25 separately, only if the patient's condition requires a significant separately identifiable service over and above the procedure performed … the documentation does not support anything over and above the laceration repair on this date of service.' However, we still disagree and feel this has been denied in error… The new patient visit should not require modifier 25 or 57 or a separate diagnosis code to be separately payable from procedure. Separate payment for this initial evaluation CPT 99202 is medically necessary, valid and billable… "

Amount in Dispute: $140.00

Respondent's Position

"… After a careful review of the documentation originally submitted with the bill and the documentation on reconsideration, Optum has determined that the documentation did not support the billed charges for a separate and distinct evaluation and management service. Although a modifier-25 was reported with the evaluation and management service, the submitted documentation did not support a significant and separately identifiable service… A review of the submitted documentation did not support the use of modifier -25 for one or more

of the previously stated reasons. The submitted medical records indicate that the history, exam, and medical decision-making were directly related to the provision of the procedure performed on the same date of service by the same clinician during the same encounter, Based on current AMA CPT guidelines, the presenting problem was addressed by the laceration repair, no additional testing was ordered or reviewed, no referrals were made, no independent historian was present, no medications prescribed, and the only follow up that was required was for suture removal, which is a global component of the laceration repair. Likewise, no time was reported.
Response Submitted by: Optum, on behalf of Sentry Casualty Co. 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.

Denial Reasons

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

- 150 – Payer deems the information submitted does not support level of service.
- P12 – Workers' Compensation Jurisdictional Fee Schedule adjustment.
- 375 + CCL – Points to Bill Comments which read: "Procedure codes Include a pre, intra, and post patient assessment. Per the AMA guidelines, an additional E/M visit CPT code may be reported separately only if the patient's condition requires a significant separately identifiable service over and above the procedure performed. The documentation does not support anything over and above the laceration repair on this date of service. There were no orders for prescription drug management, physical therapy, diagnostic testing, consultations, labs, or surgery."
- W3 – In accordance with TDI-DWC Rule 134.804, this bill had been identified as a request for reconsideration or appeal.
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

Issues

1. Is the requestor entitled to reimbursement for CPT Code 99202?

Findings

1. The requestor is seeking reimbursement in the amount of $140.00 for an evaluation and management service billed under CPT code 99202 rendered on October 12, 2022.

CPT Code 99202 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 straight forward medical decision making (MDM). When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter."

The division finds that 28 TAC §134.203(b)(1) applies to reimbursement of CPT code 99202.

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."

- Submitted documentation finds that CPT Code 12001 was included on the same bill, rendered on the same date, by the same provider as disputed service code 99202-25, has been previously reimbursed by the insurance carrier. Although CPT code 12001 is not in dispute, the billing and reimbursement of the code is relevant to the adjudication of this dispute as discussed below.
- 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 12001 has a global period of 000.

  According to National Correct Coding Initiative Policy Manual for Medicare Services, revised 1/1/2022, "... 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."

  Review of submitted medical documentation finds that disputed CPT code 99202 rendered on October 12, 2022, was inherent to the procedure of CPT code 12001 billed on same date by same provider. Submitted medical record does not support charge for a distinctly separate identifiable office visit due to: history, exam, and medical decision-making were directly related to the procedure performed on the same date of service by the same clinician during the same encounter, no additional testing was ordered or reviewed, no referrals were made, no medications prescribed, the only follow up required was for suture removal, which is a global component of CPT code 12001, laceration repair, previously reimbursed by the insurance carrier. There is no documentation of time spent on the encounter.

- The division finds that the requester is not entitled to reimbursement for CPT code 99202 rendered on October 12, 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 4, 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.