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
Mountain View Hospital

Respondent Name
Zenith Insurance Co.

MFDR Tracking Number
M4-23-2220-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
May 4, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
12/05/2022	99214-25	$216.74	$0.00
	62367	$7.89	$7.97
	Total	$224.63	$7.97

Requestor's Position

"... Per our review of the Texas Medical Fee guidelines, we find this bill to remain underpaid. This date of service was scheduled as a follow-up visit to renew the patient's pain medication for her lower back pain. The provider did refill her medications as well as review a board of pharmacy report due to chronic opiate use. In addition to the scheduled service, the provider interrogated the patient's intrathecal pump and provided the patient with a copy of the pump readout. Therefore, we billed 62367 with 99214-25 appropriately per correct coding guidelines and should be reimbursed as such. As services took place in the state of Idaho, we calculated the allowable for this bill utilizing the corresponding values per Texas guidelines... Please review and allow the requested additional reimbursement of $224.63."

Amount in Dispute: $224.63

Respondent's Position

"… The disputed code 99214-25 (evaluation and management of an established patient) was billed in combination with CPT code 62367… that has a global surgery indicator XXX." (Exhibit #5). The submitted documentation does not present a significant and separately identifiable E/M service unrelated to the decision to perform the intrathecal pump analysis (62367). Therefore, the E/M service (CPT 99214) would be considered included in the payment for CPT code 62367… "
Response Submitted by: Zenith 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 guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.
3. (TAC) §133.210 sets out medical documentation requirements.

Adjustment Reasons

The insurance carrier denied and/ or reduced the payment for the disputed services with the following claim adjustment codes:

- 97 - The benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated.
- P12 – Workers' Compensation Jurisdictional fee schedule.
- W3 - In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- Explanation of Payment message: 99214 inclusive to 62367.

Issues

1. Were the services in dispute rendered out of state?
2. Is the Requestor entitled to reimbursement for CPT code 99214-25?
3. Is the requester entitled to additional reimbursement for CPT code 62367?

Findings

1. The requestor is a health care provider that rendered disputed services in the state of Idaho to an injured employee with an existing Texas Workers' Compensation claim. The health care provider was dissatisfied with the insurance carrier's final action. The health care provider has requested medical fee dispute resolution under 28 TAC §133.307. Because the requestor has sought the administrative remedy outlined in 28 TAC §133.307, the Division concludes that it has jurisdiction to decide the issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules.

2. Requester is seeking reimbursement in the amount of $216.74 for CPT code 99214-25. The respondent denied reimbursement for CPT code 99214-25 based upon reason code 97, defined above.

   CPT code 99214 is described as "Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making (MDM). When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter."

   The requestor appended modifier 25 "Significant, Separately Identifiable Evaluation and Management (E/M) Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service" to code 99214.

   Modifier "25" is 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."

   On the disputed date of service, the requestor billed for CPT codes 99214-25 and 62367 on same date of service.

   28 TAC §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   Per 28 TAC §134.203(a)(5), the DWC referred to Medicare's coding and billing policies. The National Correct Coding Initiative Policy Manual, effective January 1, 2021, 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. The NCCI program 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, 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. 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 fee schedule, CPT code 62367, billed same date of service as CPT 99214-25, has a global surgery period of "XXX".

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."

28 Texas Administrative Code(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 (E/M) 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 99214 is one of the two highest E/M established patient office visit codes, the division finds that (TAC) §133.210(c)(1) required the requestor to submit supporting documentation to satisfy American Medical Association requirements.

- The American Medical Association (AMA) CPT Code and Guideline Changes, effective January 1, 2021, can be found at: www.ama-assn.org/system/files/2019-06/cpt-officeprolonged-svs-code-changes.pdf.
- In summary, CPT 99214 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 30-39 minutes of total time spent on the date of patient encounter.

A review of submitted medical documentation finds that a moderate level of MDM was not met in the elements of 1) Amount or complexity of problems addressed 2) Amount or complexity of data reviewed and analyzed. Submitted medical record shows no documentation of time spent on date of encounter. For these reasons, medical documentation submitted did not meet AMA criteria for reimbursement of CPT code 99214.

A review of the submitted medical 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 professional component of procedure 62367 cannot be counted as a key component of code 99214.

The division finds that the requester is not entitled to reimbursement of disputed CPT code 9921425, billed on December 5, 2022.

3. The requester seeks additional reimbursement in the amount of $7.89 for CPT code 62367 rendered on December 5, 2022.

The division finds that 28 TAC §134.203 applies to the reimbursement of CPT code 62367.

28 TAC §134.203 states in pertinent part, "(c) To determine the maximum allowable reimbursement (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 = MAR.

Date of service was rendered on December 5, 2022.

- The 2022 DWC Conversion Factor is 62.46
- The 2022 Medicare Conversion Factor is 34.6062
- Per the medical bill, the service was rendered in zip code 83201; the Medicare carrier is 02202, the locality is 00, Idaho.
- The Medicare Participating amount for CPT code 62367 in 2022 at this locality is $29.46.
- Using the above formula, the division finds the MAR is $53.17.
- The respondent paid $45.20.
- The requestor is due $7.97 for CPT code 62367 rendered on December 5, 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 established that additional reimbursement is due.

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 Zenith Insurance Co. must remit to Mountain View Hospital $7.97 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 9, 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.