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**
Sagamore Insurance Co

**MFDR Tracking Number**
M4-24-0122-01

**Carrier's Austin Representative**
Box Number 17

**DWC Date Received**
September 14, 2023

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| June 20, 2023 | 99205-25 | $423.05 | $0.00 |
| June 20, 2023 | 95866 | $381.50 | $0.00 |
| June 20, 2023 | 95912 | $482.35 | $0.00 |
| | **Total** | $1286.90 | $0.00 |

## Requestor's Position

"The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134. The carrier has not responded or has denied this claim in its entirety following our filing of Request for Reconsideration. Therefore, we are filing for Medical Dispute Resolution at this time per Rule 133.307."

**Amount in Dispute:** $1,286.90

## Respondent's Position

"On the original (first) review, Corvel deemed that the documentation submitted for 99205 did not meet AMA criteria. ...Upon request for reconsideration, the bill was reviewed by Corvel's Nurse Certified Coders who made the following determination*: Procedure services involve some degree of physician involvement or supervision which is integral to the service. Separate E/M services are not reported unless a significant, separately identifiable service is .provided.*

*Modifier 25 not supported*. …Payment was recommended for the other services billed: 95886 and 95912. Please see attached EOR recommending payment. Check #1000070796, in the amount of $863.85 was mailed 7/19/23. Said check was later returned to Protiective via USPS and was later voided. Check #1000073149, in the amount of $863.85, was reissued on 9/29/23 and mailed to Requestor."

**Response Submitted by:** Corvel

## 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 §134.225 sets the reimbursement guidelines for FCEs.

3. 28 TAC §134.203 sets out the fee guidelines for professional services.

Denial Reasons

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

- 03P – Included in another billed procedure.
- 97A – Provider appeal
- P13 – Payment reduced/denied based on state WC regs/policies
- 04P – Services unsubstantiated by documentation
- 150 – Payment adjusted/unsupported service level

Issues

1. Are the denied services supported by documentation?

2. What rule is applicable to reimbursement?

3. Is requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of Code 99205-25 rendered on June 20, 2023. The insurance carrier denied the service stating submitted documentation does not support the level of service. The AMA description of Code 99205 is "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 total time on the date of the encounter for code selection, 60 minutes must be met or exceeded."

Review of the "EMG/NCV Consultation and Testing" documentation dated June 20, 2023 indicates,

- Number and complexity of problems addressed – Low.
- Rick of complications and/or morbidity or mortality of patient management – Minimal.

The "high level" of decision making is not supported. The insurance carrier's denial based on unsubstantiated service level is upheld. No payment is recommended.

The requestor also indicates on the submitted medical bill the modifier 25 which is to be used when a significant, separately identifiable E/M service by the same physician or other qualified health care professional on the same day of a procedure or other service.

Review of the submitted "EMG/NCV Consultation and Testing" documentation does not support a separately identifiable service rendered on June 20, 2023.

Additionally, DWC Rule 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."

On the disputed date of service, the requestor billed for CPT codes 99205, 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, revised January 1, 2023, Chapter I, General Correct Coding Policies, section D, states in pertinent parts:

*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. The global period for YYY procedures is defined by the Carrier (A/B MAC processing practitioner service claims). 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 090 days, it is defined as a major surgical procedure. If an E&M service is performed on the same date of service as a major surgical procedure to decide whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57. Other preoperative E&M services on the same date of service as a major surgical*

*procedure are included in the global payment for the procedure and are not separately reportable.*

*NCCI does not contain edits based on this rule because MACs have separate edits. 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. 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.*

As previously stated, the DWC 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 was insufficient to support coding requirements."

The DWC finds that the requestor did not support the billing of CPT Code 99205 in conjunction with CPT codes 95886 and 95912. Therefore, the DWC finds that the requestor is not entitled to reimbursement for CPT Code 99205.

2. DWC Rule 28 TAC §134.203(c)(1) states "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."

   DWC Rule 28 Texas Administrative Code §134.203(c)(2) states "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.

On the disputed dates of service, the requestor billed CPT 95886 x2 and 95912. Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 75247 which is in Dallas, Texas.

- The carrier code for Texas is 4412 and the locality code for Dallas is 11.
- The CMS Physician fee schedule allowable in Dallas for Code 95886 at this locality is $99.87 x 2
- The CMS Physician fee schedule allowable in Dallas for Code 95912 is $252.54
- The DWC conversion factor for 2023 is 64.83
- The Medicare conversion factor for 2023 is 33.8872.

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

Using the above formula, the MAR for Code 95886 is $382.12. The respondent supported payment of $381.50. No additional payment is recommended.

Again, using the above formula, the MAR for code 95912 is $483.14. The respondent supported payment of $482.35. No additional payment is recommended.

3. The total allowable for the disputed services is $865.26. The insurance carrier paid $863.85 on September 26, 2023. While the requestor did not acknowledge the payment and chose to continue to MFDR, the Division finds the information submitted by the respondent supports payment was made for the disputed services. No additional payment is recommended.

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.

DWC finds the requester has not established that additional reimbursement of is due.

## Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 additional reimbursement for the disputed services.

**Authorized Signature**

| | | |
|---|---|---|
| | | December 13, 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.