



Medical Fee Dispute Resolution Findings and Decision General Information

Requestor Name

Cesar Duclair, M.D.

Respondent Name

Federal Insurance Co.

MFDR Tracking Number

M4-24-0322-01

Carrier's Austin Representative

Box Number 17

DWC Date Received

October 9, 2023

Summary of Findings

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

Requestor's Position

"Please note that an office consultation/examination was performed and documented... Additionally, as you can see from the attached report an examination was performed and documented as a Detailed Examination component and billed as 99202... 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: \$403.92

Respondent's Position

"CorVel deemed that the documentation submitted for 99205 did not meet AMA criteria... All 3 factors considered; HCP did not meet a high level of Medical Decision Making... Upon request for reconsideration, the bill was reviewed by Corvel's Nurse Certified Coders who made the following determination: *Procedural 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...* CorVel respectfully requests

the division issue a decision indicating the requestor, Cesar Pierre Duclair, entitled to \$0.00 reimbursement for date of service 10/29/2022 in the amount of \$403.92 based on failure to provide evidence supporting level of service billed."

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 §134.203](#) 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 payment for the disputed service with the following claim adjustment codes:

- 04P – Services unsubstantiated by documentation.
- 150 – Payment adjusted/unsupported service level.
- 25 – Separate E&M Service, Same physician.
- W3 – Appeal/Reconsideration
- EOB Comments: Neither a HIGH level of Medical Decision Making (MDM) or Time spent has been adequately documented in the patient record (2021 CPT). Please recode & resubmit or provide additional documentation.
- EOB Comments: HCP was referred by the Designated Doctor for EMG testing. Unclear of the need for an E/M visit at this level. The DD performed a high-level exam in determining MMI/IR.

Issues

1. What services will be reviewed in this dispute?
2. What rules apply to the disputed services?
3. Is the requestor entitled to reimbursement for CPT Code 99205-25?

Findings

1. DWC finds that CPT Codes 95886 and 95912, which were included on the DWC60 form and were on the same medical bill as the disputed evaluation and management (E/M) service, CPT code 99205-25, have been previously reimbursed by the insurance carrier. CPT Codes 95886 and 95912 are not in dispute. Therefore, only the disputed CPT code, 99205-25, will be addressed and adjudicated.

2. DWC finds that 28 TAC §133.210(c)(1) applies to the documentation requirements of CPT code 99205.

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 office visit codes for new and established patients: office visit notes/report satisfying the American Medical Association requirements for use of those CPT codes..."

DWC finds that 28 TAC §134.203(b)(1) applies to the billing and 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."

3. The requestor is seeking reimbursement in the amount of \$403.92 for CPT Code 99205-25 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 (MDM). 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 the 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) extensive level of data to be reviewed and analyzed nor 3) high risk of morbidity/mortality of patient management. Submitted medical record shows no documentation of time spent on the date of the disputed service.

- 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 billed with a modifier 25."
- See [Modifier 25 fact sheet \(novitas-solutions.com\)](#) for appropriate and inappropriate use of modifier 25 when billing for E&M service codes. In summary, appending modifier 25 to new patient E/M service codes is an inappropriate use of modifier 25.

A review of the submitted medical documentation does not support the charge for a distinctly separate office visit. Therefore, DWC finds that the requestor is not entitled to reimbursement for CPT code 99205-25 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.

DWC finds the requestor 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

_____ Signature	_____ Medical Fee Dispute Resolution Officer	<u>November 2, 2023</u> Date
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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 electrónico CompConnection@tdi.texas.gov.