TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Cesar Duclair, M.D.

Respondent Name
City of Plano

MFDR Tracking Number
M4-24-0787-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
December 7, 2023

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
August 28, 2023	99205	$423.05	$0.00
August 28, 2023	95886	$0.00	$0.00
August 28, 2023	95912	$0.00	$0.00
	Total	$423.05	$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… all components have been met for CPT Code 99202… all components are met in our documentation for CPT Code 99202…"
Amount in Dispute: $423.05

Respondent's Position

"…HCP did not meet a high level of Medical Decision Making. In fact, Dr. Duclair did not perform any decision making regarding the medical care of this claimant. The decision to provide EMG/NCV testing was made by the Designated Doctor. As such, denial payment for 99205 was maintained. 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."
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 the payment for the disputed service 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.
- EOR service line Comment: "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."

Issues

1. What service(s) are in dispute?
2. What rules apply to the disputed service?
3. Is the requestor entitled to reimbursement for CPT Code 99205-25?

Findings

1. CPT Codes 95886 and 95912, which were included on the DWC60 form and on the same bill with disputed service code 99205-25, have been reimbursed by the respondent and are not in dispute. DWC finds that the only service in dispute is CPT code 99205-25. Therefore, only 99205-25 will be addressed and adjudicated.

2. The dispute concerns an evaluation and management service (E/M) billed under CPT code 99205, appended with modifier -25.

DWC finds that 28 TAC §133.210(c)(1) applies to documentation requirements of CPT code 99205. 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 (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 99205 is one of the two highest E/M codes, DWC finds that (TAC) §133.210(c)(1) required the requestor to submit supporting documentation to satisfy American Medical Association requirements.

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 $423.05 for CPT Code 99205-25 rendered on August 28, 2023.

   - 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. 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: www.novitas-solutions.com/webcenter/portal/MedicareJL/EMScoreSheet

     A review of 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) high risk of morbidity/mortality of patient management. DWC finds no documentation of time spent specifically on separately identifiable E/M service in submitted medical record.
   - 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."

- DWC 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 the submitted medical documentation finds that disputed CPT code 99205 rendered on August 28, 2023, was inherent to the performance of CPT code 95912 billed on the same date. The submitted medical record does not support the -25-modifier appended to CPT code 99205. The requestor did not document a distinct and separately identifiable office visit.

For these reasons, DWC finds that the requestor is not entitled to reimbursement for CPT code 99205-25 rendered on August 28, 2023.

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 for the disputed service.

ORDER

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

Authorized Signature

		December 18, 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.