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
Ranil Ninala MD

Respondent Name
LM Insurance Corp

MFDR Tracking Number
M4-24-0815-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
December 11, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 24, 2023	99205	$433.11	$0.00
March 24, 2023	95886	$0.00	$0.00
March 24, 2023	95909	$0.00	$0.00
	Total	$433.11	$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 Fee Dispute Resolution at this time per Rule 133.307."

Amount in Dispute: $433.11

Respondent's Position

"The payer finds that all the service in the evaluation portion of the EMG NCV by Dr. Ninala is included in the standard pre, intra, and post work of performing the 95909. The interpretation of results of 95909 is included in the 95909 payment. Modifier 25 is not supported on 99205, there was no work above, beyond, distinct, and outside the standard pre, intra, and post work."

Response submitted by: Liberty Mutual

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 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.203 sets out the reimbursement guidelines for professional medical services.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 48 – The provider billed for a visit on the same day of surgery or within the follow-up of a previously performed surgery.
- 875 – Fee schedule amount is equal to the charge.
- 63 – The evaluation and management visit is not beyond the usual pre/post service.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $433.11 for CPT code 99205-25 rendered March 24, 2023. The respondent denied reimbursement for billing for office visit on the same day and the evaluation and management visit is not beyond the usual pre/post service.

   The fee guidelines for disputed services are found in 28 TAC §134.203. 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."

CPT code 99205 is described 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 requestor appended modifier "25" to CPT code 99205. Modifier "25" is defined 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."

A 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."

Additionally, on the disputed date of service, the requestor billed for CPT codes, 95909, 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 95909 has "XXX.

The National Correct Coding Initiative Policy Manual, effective January 1, 2023, 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.

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…

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 preprocedure, 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.***

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****..."*

*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****."*

The DWC finds the requestor's documentation does not support the high-level medical decision making or the time spent performing the evaluation. The interpretation of the EMG/NCV is the professional component of those procedures and cannot be counted as a key component of code 99205.

Based on these Medicare coding policies, the 25 modifier should not have been appended, and the evaluation and management code should not be reported.

Reimbursement is not 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 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 10, 2024 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.