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

General Information

Requestor Name
Ranil Ninala, M.D.

Respondent Name
Znat Insurance Co.

MFDR Tracking Number
M4-24-1188-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
January 29, 2024

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
March 6, 2023	99205	$408.40	$0.00
March 6, 2023	95886	$362.44	$181.52
March 6, 2023	95911	$394.11	$0.00
	Total	$1,164.95	$181.52

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."
Amount in Dispute: $1,164.95

Respondent's Position

"Based on the review and findings above, no additional payment is due for the services in dispute 99205-25, 95886 and 95911."
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 guideline for professional medical services.
3. 28 TAC §133.210 sets out medical documentation requirements for reimbursement of medical services.

Denial Reason

The insurance carrier denied the payment for the disputed service with the following claim adjustment codes:

- 205 – THIS CHARGE WAS DISALLOWED AS ADDITIONAL INFORMATION/DEFINITION IS REQUIRED TO CLARIFY.
- 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED.
- 16 – CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERRORS.
- M127 – MISSING PATIENT MEDICAL RECORD FOR THIS SERVICE.
- MA27 – MISSING /INCOMPLETE /INVALID ENTITLEMENT NUMBER OR NAME SHOWN ON THE CLAIM.
- MA30 - MISSING/INCOMPLETE/INVALID TYPE OF BILL E/M SERVICE IS NOT SIGNIFICANT
- N179 – ADDITIONAL INFORMATION HAS BEEN REQUESTED FROM THE MEMBER. THE CHARGES WILL BE RECONSIDERED UPON RECEIPT OF THAT INFORMATION.
- REMARKS: PLEASE RESUBMIT WITH CORRECT CPT CODE FOR NRV CNDJ TEST ONLY STUDIES ARE SUPPORTED AND 1 STUDY FOR THE EMG E/M SERVICE IS NOT SIGNIFICANT, OR SEPARATELY IDENTIFIABLE.

Issues

1. What rules apply to the disputed service?
2. Is the requestor entitled to reimbursement for CPT Code 99205-25?
3. Is the requestor entitled to reimbursement for CPT code 95886?
4. Is the requestor entitled to reimbursement for CPT code 95911?

Findings

1. The dispute concerns an evaluation and management service (E/M) billed under CPT code 99205-25 as well as electromyography and nerve conduction studies billed under CPT codes 95886 and 95911, respectively.

   DWC finds that 28 TAC §133.210(c)(1) applies to the 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 the services in dispute. 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."

2. The requestor is seeking reimbursement in the amount of $408.40 for CPT Code 99205-25.

   - 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: 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) extensive level of amount and/or complexity of data to be reviewed 3) high risk of morbidity/mortality of patient management. DWC finds no documentation of time spent specifically on a separately identifiable E/M service in the 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 billed 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 95911 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 report dated March 6, 2023, finds that the disputed service of the evaluation and management, represented by CPT code 99205-25, was inherent to the performance of CPT code 95911 billed on the same date. 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 on the date of service in dispute.

3. The requestor is seeking reimbursement in the amount of $362.44 for CPT code 95886 x 2 units, rendered on the disputed date of service.

   CPT code 95886 is described as "Needle Electromyography, each extremity, with related paraspinal areas, when performed with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels."

A review of the submitted medical record supports that the service of CPT code 95886 was performed on five muscles of a single extremity. Therefore, only one unit of CPT code 95886 is supported by the medical report on the disputed date of service.

DWC finds that 28 TAC §134.203, described above, applies to the reimbursement of CPT code 95886. 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.

The disputed date of service is March 6, 2023.

- The disputed service was rendered in zip code 78228, locality 99, Rest of TX, carrier 4412.
- The Medicare participating amount for CPT code 95886 in 2023 at this locality is $94.88.
- The 2023 DWC Conversion Factor is 64.83
- The 2023 Medicare Conversion Factor is 33.8872.
- Using the above formula, DWC finds the MAR is $181.52 for CPT code 95886 x 1 unit, on the disputed date of service.
- The respondent paid $0.00.
- Reimbursement in the amount of $181.52 is recommended for one unit of CPT code 95886 rendered on March 6, 2023.

DWC finds that the requestor is entitled to reimbursement in the amount of $181.52 for one unit of CPT code 95886 rendered on March 6, 2023.

4. The requestor is seeking reimbursement in the amount of $394.11 for CPT code 95911 rendered on the disputed date of service.

   CPT code 95911 is described as "Nerve conduction studies; Nine to ten nerves."

   A review of the submitted medical report finds that less than nine to ten nerves were documented as studied on the disputed date of service. Therefore, the charge for CPT code 95911 on the date of service in dispute is not supported.

   DWC finds that the requestor is not entitled to reimbursement for CPT code 95911 on the disputed date of service.

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 established that reimbursement in the amount of $181.52 is due for one unit of CPT code 95886 rendered on the disputed date of service.

ORDER

Under Texas Labor Code §§413.031, DWC has determined the requestor is entitled to reimbursement for the disputed date of service March 6, 2023. It is ordered that the Respondent, Znat Insurance Co., must remit to the Requestor, Ranil Ninala, M.D., $181.52 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		February 29, 2024
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.