



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

CESAR P. DUCLAIR, MD

Respondent Name

METROPOLITAN TRANSIT AUTHORITY

MFDR Tracking Number

M4-16-3123-01

Carrier's Austin Representative

Box Number 29

MFDR Date Received

JUNE 13, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: \$324.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOBs. Note the analysis by STARR dated 6/30/16. STARR explains the rationale for the reduction. The referral was for EMG testing only."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Rows include services for November 14, 2015 and a TOTAL row.

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced / denied by the respondent with the following reason code:
 - 165-Payment denied/reduced for absence of, or exceeded referral.
 - 165-An office visit exceeds the referral. There is no documentation submitted to support that the designated doctor referred the patient for anything other than electromyography testing.
 - P14-The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.
 - 18-duplicate claim/service.
 - W3-Additional reimbursement made on reconsideration.
 - 193-Original payment decision is being maintained. This claim was processed properly the first time.
 - W3/193-Per rule 134.804, W3 is to be used when a payment is made following a request for reconsideration. The service adjustment amount associated with this code may be zero. Original payment decision is being maintained.
 - P14-Supplies/electrodes are global of the reimbursement for the EMG/NCV.
 - 18-This is a duplicate reconsideration to previously processed ITN 01037604. Per Rule 133.240(i), when a provider is dissatisfied with the carrier's response to a request for reconsideration, the provider may file with the Division a request for medical dispute resolution within one year of the date of service.

Issues

1. Did the requestor exceed the Designated Doctor's referral?
2. Does the documentation support key components required for billing CPT code 99204?
3. Does the documentation support billing CPT code 99204?
4. Is the benefit for HCPCS code A4556 included in the benefit of another service billed on the disputed date? Is the requestor entitled to reimbursement for HCPCS code A4556?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for CPT code 99204 based upon reason code "165-Payment denied /reduced for absence of, or exceeded referral" and "165- An office visit exceeds the referral. There is no documentation submitted to support that the designated doctor referred the patient for anything other than electromyography testing."

The respondent contends that reimbursement is not due because "The referral was for EMG testing only."

The Division reviewed the submitted documentation and finds that the requestor noted on the Electromyography (EMG) Report that "The above examinee was referred for Electromyography Testing (EMG/NCV)..." The requestor did not submit a copy of the Designated Doctor's referral to support that an evaluation and management service was requested; therefore, the respondents' denial based upon reason code "165" is supported.

2. Per 28 Texas Administrative Code §134.203(a)(5), "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."

CPT code 99204 is defined as "Office or other outpatient visit for the evaluation and management of a new

patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.”

A review of the submitted medical report does not support the documentation requirement which require the 3 key components for code 99204.

1. On the disputed date of service, the requestor billed for CPT code 99204, 95910, 95886 and A4556. Per 28 Texas Administrative Code §134.203(a)(5), the Division referred to Medicare’s coding and billing policies. Per Medicare fee schedule, CPT code 95886 has a global surgery period of “ZZZ” and code 95910 has “XXX.”

The National Correct Coding Initiative Policy Manual, effective January 1, 2015, Chapter I, General Correct Coding Policies, section D, states:

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... 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, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never 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 should never 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.

The Division finds that the requestor did not identify a significant and separate E&M service to support billing CPT code 99204 in conjunction with CPT codes 95886 and 95910. In addition, the requestor did not append modifier 25 to CPT code 99204 per the correct coding guidelines. Therefore, the Division finds that the requestor’s documentation did not support billing CPT code 99204. As a result, reimbursement is not recommended.

3. HCPCS code A4556 is defined as “Electrodes (e.g., apnea monitor), per pair.”

The respondent denied reimbursement for HCPCS code A4556 based upon reason code “97.” Per Medicare guidelines, Transmittal B-03-020, effective February 28, 2003 if Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) HCPCS codes are incidental to the physician service, it is not separately payable. A review of the submitted documentation does not support a separate service to support billing HCPCS code A4556. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

8/25/2016
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.