



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

IGOR RAKOVCHIK, DO

Respondent Name

NETHERLANDS INSURANCE CO

MFDR Tracking Number

M4-17-1351-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

JANUARY 11, 2017

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: \$993.27

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider was issued \$0.00 initially and then an additional \$294.21 on 02/03/2017."

Response Submitted By: Coventry

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 20, 2016	CPT Code 99204 New Patient Office Visit	\$263.13	\$0.00
	CPT Code 95886 (X2) Needle EMG	\$294.32	\$0.00
	CPT Code 95912 Nerve Conduction Studies	\$418.92	\$0.00
	HCPCS Code A4556 Electrodes	\$16.90	\$0.00
TOTAL		\$993.27	\$0.00

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:
 - 16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
 - Documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge. Please submit documentation to substantiate charges.
 - 150-Payer deems the information submitted does not support this level of service.
 - P12-Workers' compensation jurisdictional fee schedule adjustment.
 - 112-Service not furnished directly to the patient and/or not documented.
 - 234-This procedure is not paid separately.
 - The level of E&M code submitted is not supported by documentation.
 - After review of the bill and the medical record, this service is best described by 99203. Submitted documentation did not meet the 3 key components required for 99204. Lacking a comprehensive history, a comprehensive physical examination and a medical decision of moderate complexity.
 - Payment of \$0.00 was previously issued on this claim. The payment should have been \$294.32.
 - The reimbursement is based on the CMS physician fee schedule non-facility site of service rate.
 - Documented procedure does not appear to match the code description of the CPT code billed.
 - In accordance with the CMS physician fee schedule rule for status code 'P', this service is not separately reimbursed when billed with other payable services.

Issues

1. Does the documentation support billing CPT code 99204?
2. Is the requestor entitled to additional reimbursement for CPT code 95886?
3. Does the documentation support billing CPT code 95912?
4. Is the allowance of HCPCS code A4556 included in the allowance of another procedure performed on the disputed date of service?

Findings

1. 28 Texas Administrative Code §134.203(a)(5) states "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.

In addition, on the disputed date of service, the requestor billed for CPT code 99204, 95912, 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 95909 has "XXX".

The National Correct Coding Initiative Policy Manual, effective January 1, 2016, 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 95912. 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.

2. The respondent submitted documentation to support that payment of \$294.32 was issued on February 3, 2017 for CPT code 95886 based upon the fee guidelines.

The Division refers to 28 Texas Administrative Code §134.203(c)(1)(2), which states "To determine the 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. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2016 DWC conversion factor for this service is 56.82.

The Medicare Conversion Factor is 35.8043.

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75247, which is located in Dallas, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for "Dallas, Texas".

The Medicare participating amount is \$93.14

Using the above formula, the Division finds the MAR is \$147.81 or less. The requestor billed for two units; therefore, \$147.81 X2 = \$295.62. The requestor billed a lesser amount of \$294.32. The respondent paid \$294.32. As a result, additional reimbursement is not recommended.

- 3. The respondent denied reimbursement for CPT code 95912 based upon the documentation did not support the level of service or appear to match the code descriptor. The respondent states that "9 nerves were documented as being studies this is best described by 95911."

CPT code 95912 is defined as "Nerve conduction studies; 11-12 studies."

A review of the submitted report finds 4 motor studies, 4 sensory studies, and 2 h-reflex studies for a total of 10. The Division finds the requestor did not support billing CPT code 95912. As a result, additional reimbursement is not recommended.

- 4. According to the submitted EOBs, the respondent denied payment for HCPCS code A4556 based upon reason codes "234-This procedure is not paid separately,"

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

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 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

		02/06/2017
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 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.