



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

Edward Icaza MD

Respondent Name

American Zurich Insurance Co

MFDR Tracking Number

M4-18-1250-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

December 27, 2017

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: \$154.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT Code 99203, office or other outpatient visit for the evaluation and management of a new patient, required three (3) key components: detailed history, detailed examination; and medical decision making of low complexity, was denied per Medicare guidelines and correct coding rules. Documentation does not support this level of service. The third key component, medical decision making, is not supported in the documented report. EMG/NCS diagnostic interpretation is not considered Medical Decision Making. Interpretation of the EMG/NCS is part of the professional component of those codes and should not be counted as a required key component of the E&M. CPT Code 99203 was performed together with CPT Code 95910 and CPT Code 95886, needle electromyography. CPT codes 95908 and 95886 have "XXX" and "ZZZ" global days. Medicare Correct Coding Guide indicates that E&M should not be billed with "XXX" procedures since the procedure components include the pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported with a separate E&M Code. HCPCS Codes A4556, electrodes per pair, and A4215, needle sterile any size, were denied as supplies are not separately payable per Medicare guidelines."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: August 16, 2017, 99202, A4556, A4215, \$154.44, \$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §133.20 sets out the requirements of medical bill submission by health care providers.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - X263 – The code billed does not meet the level/description of the procedure performed/documented
 - MSCP – 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
 - X212 – This procedure is included in another procedure performed on this date
 - 193 – This procedure is included in another procedure performed on this date
 - B13 – The reimbursement is based on the CMS Physician fee schedule non-facility site of service

Issues

1. Was the Code 99203 billed in accordance with the applicable fee guideline?
2. Is HCPCS code A4556 and A4215 eligible for review?

Findings

1. The requestor is seeking reimbursement in the amount of \$154.44 for professional medical services rendered on August 16, 2017.

The codes found on the DWC060 are:

- 99203 - Office or other outpatient visit for the evaluation and management of a new patient,
- A4556 – Electrodes (e.g., apnea monitor), per pair
- A4215 - Needle, sterile, any size, each

The insurance carrier denied disputed services 99203 with claim adjustment reason code X263 – "The code billed does not meet the level/description of the procedure performed/documented."

Codes A4556 was denied as MSCP – "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 and A4215 was denied as X212 – "This procedure is included in another procedure performed on this date."

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 99203 is defined as "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low 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 severity. Typically, [30](#) minutes are spent face-to-face with the patient and/or family."

Review of the document "Electromyography (EMG/NCV) with consultation dated August 16, 2017 finds;
History level – Expanded Problem Focused
Exam Level – Expanded Problem Focused
Level of Decision Making: None

Based on this review, the carrier's denial of X263 – "The code billed does not meet the level/description of the procedure performed/documented" is supported.

In addition, 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, 2017, 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 99203 in conjunction with CPT codes 95886 and 95910. In addition, the requestor did not append modifier 25 to CPT code 99203 per the correct coding guidelines. Therefore, the Division finds that the carrier's position is supported. As a result, reimbursement is not recommended.

2. The respondent states, "HCPCS Codes A4556, electrodes per pair and A4215, needle sterile any size, were denied as supplies are not separately payable per Medicare guidelines."

Review of the applicable Medicare payment policy for each of these disputed codes finds:

- Code A4556 – Status Code "P" Bundled/Excluded Codes
- Code A4215 – Status Code "X" Statutory Exclusion

Based on the above, the Carrier's denial and response is supported. No separate reimbursement recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

January 18, 2018
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *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. **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.