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
PATRICIA H. JANKI, MD

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-18-2616-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
MARCH 19, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I sent a corrected claim on 10-4-17 downcoding office visit to 99213 and the EMG codes were corrected to one unit, because I only got authorization on the right upper extremity. I have enclosed noted and emg report as well as the authorization letter. All the documentation that was submitted and billed meets the level of service billed. Please remit payment."

Amount in Dispute: $910.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT Code 99213-25 was billed in combination with codes 95911 and 95886 which have 'XXX' and 'ZZZ' global days. Medicare 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 complete. Codes with 'ZZZ' global days indicates the services are included in the global period of another related service. CPT Code 95911, nerve conduction studies, 9-10 studies, was denied as the documentation does not support the description of the billed code…Studies completed on the right upper extremity…for a total of 7 studies which does not meet the criteria for CPT Code 95911. CPT Code 95886, needle electromyography, each extremity…was denied as not separately payable without primary procedure. CPT Code 95887-59, needle electromyography, non-extremity…was denied as not separately payable without a primary procedure."

Response Submitted By: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 3, 2017	CPT Code 99213-25 Office Visit	$160.00	$119.87
	CPT Code 95911 Nerve Conduction Study	$350.00	$350.00
	CPT Code 95886 Needle EMG, One Extremity	$200.00	$150.09

August 3, 2017	CPT Code 95887-59 Needle EMG, Non-Extremity	$200.00	$0.00
TOTAL		$910.00	$619.96

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:
   - X263, W3-The code billed does not meet the level/description of the procedure performed/documented. Consideration will be given with coding that reflects the documented procedure.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - U058-Procedure code should not be billed without appropriate primary procedure.

Issues

1. What is the applicable fee guideline for professional services?
2. Does the documentation support billing CPT code 99213-25? Is the requestor entitled to reimbursement?
3. Does the documentation support billing CPT code 95911? Is the requestor entitled to reimbursement?
4. Did the requestor bill for CPT code 95886 appropriately? Is the requestor entitled to reimbursement?
5. Did the requestor bill for CPT code 95887-59 appropriately? Is the requestor entitled to reimbursement?

Findings

1. The fee guidelines for disputed services are found in 28 Texas Administrative Code §134.203.
2. The respondent denied reimbursement for CPT code 99213-25, based upon reason code "X263-The code billed does not meet the level/description of the procedure performed/documented. Consideration will be given with coding that reflects the documented procedure."

   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 described as "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and 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 low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family."

   The requestor appended modifier "25- Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service."

On the disputed date of service, the requestor billed for CPT code 99213-25, 95911, 95886, and 95887-59. 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 95911 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 respondent wrote, "CPT Code 99213-25 was billed in combination with codes 95911 and 95886 which have 'XXX' and 'ZZZ' global days. Medicare 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 complete. Codes with 'ZZZ' global days indicates the services are included in the global period of another related service."

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 Division finds that the requestor's E&M report supports a separate identifiable E&M service, and it meets two of the three required key components for billing CPT code 99213-25. As a result, reimbursement is recommended.

Per 28 Texas Administrative Code §134.203(c)(1)(2), "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 2017 DWC conversion factor for this service is 57.5.

The Medicare Conversion Factor is 35.8887

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77015, which is located in Houston Texas. Therefore, the Medicare participating amount will be based on the reimbursement for locality "Houston, Texas".

The Medicare participating amount for 99213 is $74.82.

Using the above formula, the Division finds the MAR is $119.87. The respondent paid $0.00. Therefore, the requestor is due $119.87.

3. According to the explanation of benefits, the respondent denied reimbursement for CPT code 95911 based upon reason code "X263-The code billed does not meet the level/description of the procedure performed/documented. Consideration will be given with coding that reflects the documented procedure."

   CPT code 95911 is described as "Nerve conduction studies; 9-10 studies."

   A review of the submitted report indicates bilateral sensory conduction, motor conduction with or without F-wave testing of the Median, Radial and Ulnar nerves. The division finds the report supports billed service; therefore, reimbursement per 28 Texas Administrative Code §134.203(c)(1)(2) is recommended,

   The Medicare participating amount for 95911 is $241.86.

   Using the above formula, the Division finds the MAR is $387.50 or less. The requestor is seeking a lesser amount of $350.00. The respondent paid $0.00. Therefore, the requestor is due $350.00.

4. According to the explanation of benefits, the respondent denied reimbursement for CPT code 95886 based upon reason code "U058- Procedure code should not be billed without appropriate primary procedure."

   CPT code 95886 is described as "Needle electromyography, each extremity, with related paraspinal areas, when performed, done 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 (List separately in addition to code for primary procedure)."

   CPT code 95886 is an add-on code, that describes additional work performed with the primary procedure.

   The primary procedure is the nerve conduction study (NCS) . A review of the submitted medical bill finds that the requestor billed the needle EMG in conjunction with a NCS; therefore, the respondent's denial is not supported. Therefore, reimbursement per 28 Texas Administrative Code §134.203(c)(1)(2) is recommended.

   The Medicare participating amount for 95886 is $93.68.

   Using the above formula, the Division finds the MAR is $150.09. The respondent paid $0.00. Therefore, the requestor is due $150.09.

1. According to the explanation of benefits, the respondent denied reimbursement for CPT code 95887-59 based upon reason code "U058- Procedure code should not be billed without appropriate primary procedure."

   CPT code 95887 is described as "Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure)."

   The requestor appended modifier "59" to code 95887. Modifier "59" is defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

The division reviewed the submitted medical billing and reports and finds:

- CPT code 95887 is an add-on code that was billed with the primary procedure CPT code 95911.
- A review of the submitted reports does not support a "different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual." The Division finds that the requestor has not supported the use of modifier "59."
- Requestor did not support billing CPT code 95887-59.

Based upon the division's findings reimbursement is not recommended for CPT code 95887-59.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $619.96 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		04/12/2018
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.