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

General Information

Requestor Name
Donald Martin McPhaul MD

Respondent Name
Accident Fund Insurance Company

MFDR Tracking Number
M4-24-0323-01

Carrier's Austin Representative
Box Number 06

DWC Date Received
October 6, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 19, 2023	99205-25, 95886, and 95912	$1,286.90	$863.85
	Total	$1,286.90	$863.85

Requestor's Position

"DESIGNATED DR REFERRED TESTING NO PAYMENT RECEIVED."

Amount in Dispute: $1,286.90

Respondent's Position

The Austin carrier representative for Accident Fund Insurance Company of America is Stone Loughlin Swanson. Stone Loughlin Swanson was notified of this medical fee dispute on October 17, 2023. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under 28 TAC §133.307(d)(1).

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
2. 28 Texas Administrative Code (TAC) §133.305 sets out the procedures for resolving medical disputes.
3. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 TAC §134.203 sets out the fee guideline for professional medical services.
5. 28 TAC §127.10 sets out the general procedures for Designated Doctor examinations.

Denial Reasons

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

- TX W3 – The benefit for this service is included in the payment/allowance for another service/procedure that has been performed on the same day.
- @G(W3) – No additional reimbursement allowed after review of appeal/reconsideration.
- 1115 – RECON: We find the previous review to be accurate and are unable to recommend any additional allowance.
- 5089 – Service(s) not authorized.
- 5098 – This billing is for a service unrelated to the work injury/illness.
- 5180 – Bill denied as the injury is not work related.
- 5347 – Services are unreasonable and unnecessary.
- Coventry Health Care (TX HCN) The payment was reviewed using an existing PPO contract arrangement.

Issues

1. Is the insurance carrier's denial supported?
2. Is the requestor entitled to reimbursement for CPT code 99205-25
3. Is the requestor entitled to reimbursement for CPT codes 95886 and 95912?
4. What are the fee guidelines for reimbursement of the disputed services?

Findings

1. This dispute pertains to the non-payment of designated doctor ordered evaluation and testing services rendered on July 19, 2023, and billed under CPT codes 99205-25, 95886, and 95912. The requestor is seeking a total payment in the amount of $1,286.90.

   Using the previously mentioned denial reduction codes indicated above, the insurance carrier audited and denied the disputed services due to service unrelated to work injury/illness, services are unreasonable and unnecessary, services not authorized, and reviewed using an existing PPO contract arrangement. The disputed services are reviewed pursuant to the applicable rules and guidelines.

   28 TAC §127.10(c) states, "Additional testing and referrals. The designated doctor must perform additional testing when necessary to resolve the issue in question. The designated doctor must also refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question, and the designated doctor is not qualified to fully resolve it.

   > (1) Any additional testing or referrals required for the evaluation are not subject to preauthorization requirements.
   >
   > (2) Payment for additional testing or referrals that the designated doctor has determined are necessary under this subsection must not be denied prospectively or retrospectively, regardless of any potential disagreements about medical necessity, extent of injury, or compensability.
   >
   > (3) Any additional testing or referrals required for the evaluation are subject to the requirements of §180.24 of this title (relating to Financial Disclosure).
   >
   > (4) Any additional testing or referrals required for the evaluation of an injured employee under a certified workers' compensation network under Insurance Code Chapter 1305 or a political subdivision under Labor Code §504.053(b):
   >
   > > (A) are not required to use a provider in the same network as the injured employee; and
   > >
   > > (B) are not subject to the network or out-of-network restrictions in Insurance Code §1305.101 (relating to Providing or Arranging for Health Care)."

   Based upon the submitted documentation, the claimant was referred to the requestor by the Designated Doctor, Michael Leonard, MD. The DWC finds that the insurance carrier's denial reasons are not supported, and therefore, the disputed services are reviewed pursuant to the applicable rules and guidelines.

2. The requestor is seeking reimbursement of Code 99205-25 rendered on July 19, 2023.

   TAC §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."

The description of CPT code 99205 is "Office or other outpatient visit for 3 the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded."

The requestor appended modifier -25 to CPT code 99205 to" indicate that a patient's condition required a significant, separately identifiable evaluation and management (E/M) service above and beyond that associated with another procedure or service being reported by the same physician or other qualified health care professional on the same date."

The requestor billed CPT codes 99205-25, 95886, and 95912 on July 19, 2023. A review of the submitted "EMG/NCV Consultation and Testing" report, does not support a separately identifiable service rendered on that day. As a result, the requestor is not entitled to reimbursement for CPT code 99205-25 rendered on July 19, 2023.

3. The requestor seeks reimbursement for CPT codes 95886 and 95912 rendered on July 19, 2023.

   28 TAC §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."

   On the disputed date of service, the requestor billed CPT codes 99205-25, 95912, and 95886. Per 28 TAC §134.203(a)(5), the DWC referred to Medicare's coding and billing policies.

   Per Medicare fee schedule,

   CPT code 95886 has a global surgery period of "ZZZ", and code 95912 has "XXX". The National Correct Coding Initiative Policy Manual, revised January 1, 2023, Chapter I, General Correct Coding Policies, section D, states in pertinent parts: Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

   > 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… Since NCCI PTP edits are applied to same-day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI.

An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances. If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M service is performed on the same date of service as a major surgical procedure to decide whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57. Other preoperative E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable.

NCCI does not contain edits based on this rule because MACs have separate edits. If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. In general, E&M services performed on the same date of service as a minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and shall not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider/supplier is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure.

NCCI contains many, but not all, possible edits based on these principles. 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, intraprocedural, and post-procedure work usually performed each time the procedure is completed. This work shall not 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 shall not 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.

As previously stated, the DWCs review of the submitted report does not support a significant, separately identifiable E/M service above and beyond the other service provided.

The DWC finds that the requestor did not support the billing of CPT Code 99205 in conjunction with CPT codes 95886 and 95912. Therefore, the DWC finds that the requestor is not entitled to reimbursement for CPT Code 99205-25. Based on the above findings, the DWC finds that the requestor has established that reimbursement is due for CPT codes 95886 x 2 units and 95912.

4. DWC Rule 28 TAC §134.203(c)(1) 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."

   DWC Rule 28 TAC §134.203(c)(2) states "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 Medicare conversion factor for 2023 is 33.8872. To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR). The DWC conversion factor for 2023 is 64.83

   - On the disputed date of service, the requestor billed CPT 95886 x2 and 95912.
   - Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 75247 which is in Dallas, Texas.
   - The carrier code for Texas is 4412 and the locality code for Dallas is 11.

   - The CMS Physician fee schedule for CPT code 95886 at this locality is $99.87 x 2.
   - Using the above formula, the MAR amount is $191.06 x 2 units = $382.12
   - The requestor seeks $381.50; therefore, this amount is recommended.

   - The CMS Physician fee schedule allowable for CPT code 95912 at this locality is $252.54.
   - Using the above formula, the MAR amount is $483.14.
   - The requestor seeks $482.35; therefore, this amount is recommended.

   The DWC finds that the requestor is entitled to reimbursement in the amount of $863.85. This amount is recommended.

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.

The DWC finds the requester has established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $863.85 reimbursement for the disputed services. It is ordered that Respondent must remit to Requestor $863.85 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		April 10, 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, 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.