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

General Information

Requestor Name
Joel Joselevitz, MD

Respondent Name
American Zurich Insurance Company

MFDR Tracking Number
M4-24-1142-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
January 23, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 6, 2023	99205, 95886 (2) and 95911	$1,233.36	$807.54
	Total	$1,233.36	$807.54

Requestor's Position

"WORK COMP TREATMENT AND SERVICES NO PAYMENT RECEIVED."

Amount in Dispute: $1,233.36

Respondent's Position

"It remains the carrier's position that the diagnosis is inconsistent with the procedure."

Response Submitted by: Flahive, Ogden & Latson

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the fee guideline for professional medical services.

Denial Reasons

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

- 11 – The diagnosis is inconsistent with the procedure.
- W3 – In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- Note: No allowance changes.

Issues

1. Did the insurance carrier submit a copy of a PLN11 in support of the denial reason?
2. Does the documentation support the billing of CPT codes 99205-25, 95886 (2) and 95911?
3. Is the requestor entitled to reimbursement for the services in dispute?

Findings

1. The requestor seeks reimbursement for services rendered on November 6, 2023. The insurance carrier denied the disputed services due to diagnosis is inconsistent with the procedure.

   The insurance carrier states in pertinent part, "It remains the carrier's position that the diagnosis is inconsistent with the procedure."

   28 TAC §133.305(b) states that if a dispute over the extent of a work injury exists for the same service for which there is a medical fee dispute, the dispute regarding the extent of injury shall be resolved prior to the submission of a medical fee dispute.

   28 TAC 133.307(d)(2)(H), states, "(d) Responses. Responses to a request for MFDR must be legible and submitted to the division and to the requestor in the form and manner prescribed by the division… (2) Response. On receipt of the request, the respondent must provide any missing information not provided by the requestor and known to the respondent. The respondent must also provide the following information and records… (H) If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier must attach any related Plain Language Notice in accordance with §124.2 of this title (concerning Insurance Carrier Reporting and Notification Requirements)."

   A review of the documentation submitted by the parties finds that the carrier did not provide documentation to the DWC to support that it filed a Plain Language Notice (PLN) regarding

the disputed conditions as required by §133.307(d)(2)(H).

The respondent did not submit information to MFDR, sufficient to support that the PLN had ever been presented to the requestor or that the requestor had otherwise been informed of PLN prior to the date that the request for medical fee dispute resolution was filed with the DWC; therefore, the DWC finds that the extent of injury denial was not timely presented to the requestor in the manner required by 28 TAC §133.240. Because the service in dispute does not contain an unresolved extent of injury issue, this matter is eligible for adjudication of a medical fee pursuant to 28 TAC §133.307. For that reason, this matter is addressed in accordance with the applicable rules and guidelines.

2. The requestor seeks reimbursement for CPT Codes 99205-25, 95886 (2) and 95911 rendered on November 6, 2023.

   The fee guidelines for the disputed services are found in 28 TAC §134.203.

   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."

   CPT code 99205 is defined as "Office or other outpatient visit for 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."

   On the disputed date of service, the requestor billed CPT Codes 99205-25, 95886 (2) and 95911. Pursuant to 28 TAC §134.203(a)(5), the DWC refers to the Medicare's coding and billing policies. Per Medicare fee schedule, CPT code 95886 has a global surgery period of "ZZZ", and code 95911 has an "XXX".

   The National Correct Coding Initiative Policy Manual, effective January 1, 2016, Chapter I, General Correct Coding Policies, section D, states:

   > 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 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 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."

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."

A review of the submitted report does not support "a significant, separately identifiable E/M service above and beyond the other service provided," and "documentation that satisfies the relevant criteria for the respective E/M service to be reported."

The DWC finds that the requestor did not support the billing of CPT Code 99205-25 in conjunction with CPT codes 95886 and 95911. As a result, the requestor is not entitled to reimbursement for CPT Code 99205-25.

3. Rule §134.203 applies to CPT codes 95886 (2) and 95911.

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

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).

28 TAC §134.203(b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

Review of the submitted documentation supports the billing of CPT codes 95911 and 95886 (2). As a result, the requestor is entitled to reimbursement for these charges.

28 TAC §134.203 states in pertinent part, "(c) 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..."

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

- The disputed service was rendered on November 6, 2023.
- The 2023 DWC Conversion Factor is 64.83
- The 2023 Medicare Conversion Factor is 33.8872
- Per the medical bills, the services were rendered in zip code 78752; the Medicare locality is "Austin."

The Medicare Participating amount for CPT code 95911 in this locality is $219.10.

- Using the above formula, the DWC finds the MAR is $419.16.
- The respondent paid $0.00.
- The requestor seeks $418.48, as a result this amount is recommended.

The Medicare Participating amount for CPT Code 95886 in this locality is $101.85.

- Using the above formula, the DWC finds the MAR is $194.85 x 2 units = $389.70.
- The respondent paid $0.00.
- The requestor seeks $389.06, as a result this amount is recommended.

The DWC finds that the requestor is entitled to the total recommended amount of $807.54.

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 of $807.54 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor $807.54 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	_____	April 15, 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.