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

General Information

Requestor Name
Joel Joselevitz, M.D.

Respondent Name
Old Republic Insurance Co.

MFDR Tracking Number
M4-24-1342-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
February 16, 2024

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
July 5, 2023	99205	$433.11	$0.00
July 5, 2023	95886	$0.00	$0.00
July 5, 2023	95912	$487.26	$0.00
	Total	$920.37	$0.00

Requestor's Position

"Please note that an office consultation/examination was performed and documented separately on this date of service and billed accordingly with the appropriate modifier… as you can see from the attached report an examination was performed and documented as a Detailed Examination component and billed as 99202… all components have been met for CPT Code 99202…"
Amount in Dispute: $920.37

Respondent's Position

"… we have escalated the bills in question for manual review to determine if additional monies are owed. We will provide a supplemental response once the bill auditing company has finalized their review."
*DWC notes that as of the date of this review, no supplemental response has been submitted.
Response Submitted by: Gallagher Bassett

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.
3. 28 TAC §133.210 sets out medical documentation requirements for reimbursement of medical services.

Denial Reasons

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

- P12-1 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 90403 - SERVICE NOT FURNISHED DIRECTLY TO THE PATIENT AND/OR NOT DOCUMENTED.
- 90168 - PAYMENT ADJUSTED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE.
- 5352 - CV: SERVICE-REDUCED/DENIED AS LEVEL OF E&M CODE SUBMITTED IS NOT SUPPORTED BY DOCUMENTATION.
- 5346 – CV: DOCUMENTED PROCEDURE DOES NOT APPEAR TO MATCH THE CODE DESCRIPTION OF THE CPT CODE BILLED.
- 309 - THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
- 0663 - REIMBURSEMENT HAS BEEN CALCULATED ACCORDING TO STATE FEE SCHEDULE GUIDELINES.
- 150-1 – PAYMENT ADJUSTED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE.

Issues

1. What rules apply to the disputed service?
2. Is the requestor entitled to reimbursement for CPT Code 99205?
3. Is the requestor entitled to reimbursement for CPT Code 95912?

Findings

1. The dispute concerns an evaluation and management service (E/M) billed under CPT code 99205-25 and a nerve conduction study service billed under CPT code 95912, both rendered on July 5, 2023.

   DWC finds that 28 TAC §133.210(c)(1) applies to documentation requirements of CPT code 99205. 28 (TAC) §133.210(c)(1) sets out medical documentation requirements, stating in pertinent part "In addition to the documentation requirements of subsection (b) of this section, medical bills for the following services shall include the following supporting documentation: the two highest Evaluation and Management (E/M) office visit codes for new and established patients: office visit notes/report satisfying the American Medical Association requirements for use of those CPT codes…"

   As CPT code 99205 is one of the two highest E/M codes, DWC finds that (TAC) §133.210(c)(1) required the requestor to submit supporting documentation to satisfy American Medical Association requirements.

   DWC finds that 28 TAC §134.203(b)(1) applies to the billing and reimbursement of both CPT codes in dispute. 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."

2. The requestor is seeking reimbursement in the amount of $433.11 for CPT Code 99205 rendered on July 5, 2023.

   - 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 (MDM). When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter."

   - The American Medical Association (AMA) CPT Code and Guideline Changes, effective January 1, 2021, can be found at: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf. In summary, CPT 99205 documentation must contain two out of three of the following elements: 1) high level of number and complexity of problems addressed 2) extensive level of amount and/or complexity of data to be reviewed and analyzed 3) high risk of morbidity/mortality of patient management OR must document 60-74 minutes of total time spent on the date of patient encounter.

   - An interactive Evaluation and Management (E/M) scoresheet tool is available at: www.novitas-solutions.com/webcenter/portal/MedicareJL/EMScoreSheet

A review of submitted medical documentation finds that a high level of MDM was not met in the elements of 1) number and complexity of problems addressed 2) high risk of morbidity/mortality of patient management. DWC finds no documentation of time spent specifically on a separately identifiable E/M service in the submitted medical record.

- Per CMS article, found at:

  Article - Billing and Coding: Nerve Conduction Studies and Electromyography (A57478) (cms.gov), "I. Coding Guidelines A.) Evaluation/Management (E/M) 1) Usually an E&M service is included in the exam performed just prior to and during nerve conduction studies and/or electromyography. If the E&M service is a separate and identifiable service, the medical record must document medical necessity and the CPT code must be bill with a modifier 25."

- DWC applies Medicare's coding and billing policies in accordance with 28 TAC §134.203 as indicated above. Per Medicare Fee Schedule, CPT code 95912 has a global period of XXX.

  According to National Correct Coding Initiative Policy Manual for Medicare Services, revised 5/1/2022, "… 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 shall not be reported as a separate E&M code… 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..."

A review of the submitted medical documentation finds that disputed CPT code 99205-25 rendered on July 5, 2023, was inherent to the performance of CPT code 95912 billed on the same date. The requestor did not document a distinct and separately identifiable office visit.

For these reasons, DWC finds that the requestor is not entitled to reimbursement for CPT code 99205-25 rendered on July 5, 2023.

3. The requestor is seeking reimbursement in the amount of $487.26 for CPT code 95912 rendered on July 5, 2023.

   - CPT code 95912 is defined as "nerve conduction test, 11 to 12 studies."
   - DWC applies Medicare's coding and billing policies in accordance with 28 TAC §134.203 as indicated above.
   - According to Billing and Coding: Nerve Conduction Studies and Electromyography, CMS Article ID: A54992, section B. Nerve Conduction Studies… "5. Codes 95907-95913 describe one or more nerve conduction studies. A single conduction test is defined as a sensory conduction test, a motor conduction test with or without an F wave test, or an

H-reflex test. Each type of study (sensory, motor with or without F wave, H-reflex) for each anatomically distinct and separately named nerve is counted as a distinct study when determining the number of studies billed. Each type of study is counted only once when multiple sites on the same nerve are stimulated and recorded. The number of tests (sensory, motor with or without F wave, H-reflex) per nerve are added to determine the code to be billed."

A review of the submitted medical documentation finds that the number of studies documented does not support the billing of CPT code 95912, "11 to 12 studies." Therefore, DWC finds that the requestor is not entitled to reimbursement for CPT code 95912.

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.

DWC finds the requestor has not established that reimbursement is due for the disputed services.

ORDER

Under Texas Labor Code §§413.031, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed service.

Authorized Signature

		May 29, 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.