Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

AMBULATORY ADULT NEUROLOGY PA
2601 HOSPITAL BLVD 206E
CORPUS CHRISTI TX 78405

Respondent Name
ZURICH AMERICAN INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-08-3597-01

MFDR Date Received
FEBRUARY 7, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We filed this claim 10-11-07 it got denied 'payment is adjusted when billed by provider of this specially,' I appealed with letter of reconsideration they did not respond."

Amount in Dispute: $669.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier's position remains consistent with its EOBs."

Respondent's Supplemental Position Summary dated April 4, 2008: "Carrier has previously responded to this dispute on 02/26/2008 and 4/03/08. The carrier is attaching the EOB that corresponds with payment of $324.86."

Responses Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 11, 2007	CPT Code 95860 Needle EMG, one extremity with or without related paraspinal areas	$229.00	$0.00
October 11, 2007	CPT Code 95903-59-76 (x2) Nerve Conduction Study, each nerve, motor with F-wave study	$204.00	$0.00
October 11, 2007	CPT Code 95904-76 (x2) Nerve Conduction Study, each nerve, sensory	$166.00	$0.00
October 11, 2007	CPT Code 99080 Special Report	$70.00	$0.00
TOTAL		$669.00	$0.00

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 a medical fee dispute.
2. 28 Texas Administrative Code §134.202, effective August 1, 2003, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.120, effective May 2, 2006, sets out the reimbursement guidelines for medical documentation.
4. 28 Texas Administrative Code §133.210, effective May 2, 2006, outlines medical documentation requirements for medical bill processing.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 17-(172)-Payment is adjusted when performed/billed by a provider of this specialty.
   - 24, 17-(172)-This line was included in the reconsideration of this previously reviewed bill.
   - This bill was reviewed in accordance with your fee for service contract with First Health.

Issues

1. Does a contractual agreement issue exist in this dispute?
2. Is the requestor entitled to reimbursement for CPT codes 95860, 95903, 95904?
3. Is the requestor entitled to reimbursement for CPT code 99080?

Findings

1. According to the submitted explanations of benefits, the insurance carrier denied reimbursement for the disputed services based upon "This bill was reviewed in accordance with your fee for service contract with First Health." Review of the submitted information found no documentation to support that the disputed services were subject to a contractual agreement between the parties to this dispute. On January 6, 2011, the Division requested the respondent to provide a copy of the referenced contract between the network and the health care provider, pursuant to Division rule at 28 TAC §133.307(l), which states that "The commission may request other additional information from either party to review the medical fee issues in dispute. The other additional information shall be received by the division within 14 days of receipt of this request." The respondent failed to provide a copy of the additional requested documents. The respondent has not supported the above denial/reduction explanations. For this reason, the disputed services will be reviewed for payment in accordance with applicable Division fee guidelines.
2. The respondent denied reimbursement for the nerve studies and report based upon "17-(172)-Payment is adjusted when performed/billed by a provider of this specialty." A review of the medical bill and report finds that the services were rendered by J. Felipe Santos, MD. The respondent did not submit any documentation to support that a medical physician's payment should be adjusted. Therefore, reimbursement per Division rules and guidelines is recommended.

   28 Texas Administrative Code §134.202(b) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section."

   28 Texas Administrative Code §134.202(c)(1) states "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: "for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%."

   According to the submitted medical bills, the services were performed in Corpus Christi, Texas; therefore, the Medicare carrier locality is "Rest of Texas."

CPT CODE	MEDICARE ALLOWABLE	MEDICARE ALLOWABLE x 125%	TOTAL NUMBER OF UNITS	TOTAL MAR	TOTAL PAID	AMOUNT DUE

95860	$80.20	$100.25	1	$100.25	$100.26	$0.00
95903	$60.33	$75.41	2	$150.82	$150.82	$0.00
95904	$47.25	$59.06	2	$118.12	$118.12	$0.00

3. The respondent denied reimbursement for CPT code 99080-special reports based upon reason code "17-(172)- Payment is adjusted when performed/billed by a provider of this specialty." The respondent did not submit any documentation to support this denial reason. Therefore, the disputed service will be reviewed per Division rules and guidelines.

   28 Texas Administrative Code §134.120(a) and (b) states "An insurance carrier is not required to reimburse initial medical documentation provided to the insurance carrier in accordance with §133.210 of this title (relating to Medical Documentation). (b) An insurance carrier shall separately reimburse subsequent copies of medical documentation requested by the insurance carrier in accordance with §133.210 of this title."

   28 Texas Administrative Code §133.210(b) states "When submitting a medical bill for reimbursement, the health care provider shall provide required documentation in legible form, unless the required documentation was previously provided to the insurance carrier or its agents."

   A review of the submitted documentation does not support that the requestor requested the report in accordance with 28 Texas Administrative Code §134.120(b). A review of the submitted reports finds that the only report that was submitted was for the nerve studies. The nerve study report is part of the service billed under CPT codes 95860, 95903 and 95904. A separate report to support billing CPT code 99080 was not submitted. As a result, reimbursement is not 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 upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	02/28/2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.