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

MEYER L PROLER MD & ASSOCIATES
1001 TEXAS AVENUE SUITE 450
HOUSTON TX 77002

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-11-1953-01

MFDR Date Received
JANUARY 27, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary dated January 26, 2011: "Texas Mutual denied payment for the attached claims because (i) Dr. Proler did not disclose his ownership interest in StatLink Manager and/or (ii) he did not provide the appropriate level of supervision to give him the right to bill for the technical component of the services. As demonstrated above:

1. Dr. Proler had absolutely no obligation under DWC rules to disclose his ownership interest in StatLink because: a. StatLink, a management company, b. As a management company StatLink provides no health care services and is not a health care provider; and c. Dr. Proler refers no patients to StatLink.
2. The use of the real time, visual and audio telemedicine technology allows Dr. Proler to supervise the technician providing the technical portion of the IOM EMG services as if he were in the same room with the technician and surgical team, thereby meeting the requirement for direct supervision required by the DWC rules.
3. Physician supervision of technicians assisting in the performance of EMGs furnished as part of a remote IOM procedure provided through the use of telemedicine technology is accepted by Medicare and virtually every commercial payor."

Requestor's Position Summary dated April 1, 2011: "In those original appeals and communications with Texas Mutual, StatLink/Proler attempted to explain to Texas Mutual that Diagnostic EMGs and IOM/EMGs are separate and distinct procedures that are coded and paid differently, and are furnished for different purposes. These attempts to clarify the distinctions between the two types of procedures was apparently unsuccessfully as Texas Mutual continues to treat office-based Diagnostic EMGs and IOM/EMGs performed through the use of live, interactive technology ('telemedicine') during a surgical procedure as one and the same procedure. The difference in these procedures is found not only in the site of service, the types of provider furnishing the service, the purpose of the procedure, the credentialing required for the providers, but also in how the procedures are coded. IOM/EMGs are coded with AMA CPT 95920 whereas Diagnostic EMGs are coded with CPT 95860-95872." "Texas Mutual's classification of StatLink as a health care provider is important because Dr. Proler owns 50% of StatLink. If StatLink were actually a health care provider, this ownership by Dr. Proler would trigger a notification obligation by Dr. Proler, which was admittedly not made." "The Texas Labor Code §401.00(22) clearly and succinctly defines a health care provider as *'a health care facility or health care practitioner.'* StatLink is clearly not a facility. Therefore, StatLink would have to qualify as a '*health care practitioner'* to be considered a health care provider. The same section of the Texas Labor Code defines health care practitioner as *'an individual who is licensed to provider or render and provider or renders health care'.* StatLink does not hold and is not eligible for any State license and thus none of its three legally distinct corporate entities is an individual licensed to provider and render health care." "Dr. Proler has no disclosure obligation with respect to these contracted technicians because he *does not refer patients to them*. The technicians whose services are billed by Dr. Proler are certified neurological intraoperative monitoring technicians ('CNIMs'), and are not permitted by their

certification to provide independent, unsupervised health care services to patients." "All physicians have some sort of compensation arrangement with the nurses and technicians who work in the offices…yet Texas Mutual is expecting Dr. Proler to disclose the fact that he pays these CNIMs to assist him with the IOM/EMG procedures. Clearly that is not what the DWC intended by this rule and Texas Mutual should not have denied payment on that basis." "…these CNIMs are directly supervised by Dr. Proler with the aid of interactive telemedicine technology, and Dr. Proler complied with the Texas telemedicine rules when supervising the CNIMs and furnishing the ION/EMG services." "Texas Mutual states that Dr. Proler paid refunds on certain cases upon receipt of Texas Mutual's demand letter in January 2010…StatLink/Proler had attempted to get some clarification from Texas Mutual on the reason for the demand, but when they were unable to get clarification from Texas Mutual, they made a business decision to respond to the demand letter…StatLink did not agree with the reason for Texas Mutual's denial, at that or any other time."

Amount in Dispute: $1,686.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated March 11, 2011: "On July 29, 2009, Texas Mutual conducted an onsite audit of Dr. Proler's billings pursuant to Rule 133.230. Based on the information obtained through that audit, Texas Mutual determined that the services were not payable for several reasons…Texas Mutual issues its final audits on October 21, 2009, denying the services and requesting refunds of prior amounts paid…On January 19, 2010, Statlink, apparently agreeing with Texas Mutual's position, issued payment for both refunds. *Attachment B*." "This is a medical fee dispute involving charges for electromyograms (EMGs) intraoperative monitoring services (IOMs) where the testing is performed by technicians who, approximately 90% of the time, are licensed chiropractors. The IOMs are done by telemedicine. Even though the technical component is done by others, the entire procedure is billed in Dr. Proler's name in block 31 of the CMS-1500. *This is true even if the technician performing the test is individually licensed."* "The billing is done through Statlink, which claims to be a company that provides management and other administrative services to physician practices. Texas Mutual does not necessarily agree with this given the description of the company on its website. *See Attachment E*. It appears that StatLink itself is a health care provider under the Texas Labor Code definition in section 401.011(22)." "Dr. Proler owns 50% of Statlink…Dr. Proler and Statlink contract with other providers. *Attachment D, page 5*. Statlink keeps a portion of the payments collected on behalf of other providers. *Attachment D and Attachment F*." "Thus, based on DWC rules, billing Dr. Proler's name in block 31 of the CMS-1500 is correct, at least as to the technical component of the IOMs, only if Dr. Proler provided direct supervision. And payment would be appropriate only if he provided direct supervision. However, according to StatLink's admission, he did not. Further, billing Dr. Proler's name in block 31 of the CMS-1500 would be correct, again at least as to the technical components of the IOMs, only if the technician performing the services was not individually licensed. StatLink indicated that this is not always the case." "With respect to financial disclosure, Ms. Geroulo's stated in her November 16 letter: 'We do not dispute that Dr. Proler has an obligation to disclose an ownership interest he might hold in a company or entity to which he is referring patient for 'health care services'." *Attachment D, page 4.* "DWC Rule 180.24(b)(2). Failure to have properly disclosed any financial interest as defined in the rule is subject to forfeiture of the right to reimbursement."

Supplemental Position Summary Response: In addition to the Carrier's Statement on Disputed Issues (attached), Texas Mutual provides the following explanation for the additional denial reasons for date of service February 3, 2010." "In its review of the bill Texas Mutual noted that Dr. Proler billed the whole procedure when the documentation submitted indicates he performed only the professional component, which would require the modifier 26. Dr. Proler did not bill with modifier 26."

Response Submitted by: Texas Mutual Insurance Co., 6210 East Highway 290, Austin, TX 78723-1098

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 3, 2010	CPT Code 95920 (2) - Intraoperative neurophysiology testing, per hour (List separately in addition to code for primary procedure)	$453.70	$0.00
	CPT Code 95822 - Electroencephalogram (EEG); recording in coma or sleep only	$380.20	$0.00
	CPT Code 95925 - Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs	$192.71	$0.00

	CPT Code 95926- Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs	$189.12	$0.00
	CPT Code 95904 (4) - Nerve conduction, amplitude and latency/velocity study, each nerve; sensory	$288.24	$0.00
	CPT Code 95861 - Needle electromyography; 2 extremities with or without related paraspinal areas	$182.59	$0.00
TOTAL		$1,686.56	$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, effective May 25, 2008, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. Texas Labor Code §401.011, effective September 1, 2009 defines a health care provider.
4. 28 Texas Administrative Code §180.24 effective March 14, 2002, sets out the financial disclosure requirements and penalties for healthcare providers.
5. 28 Texas Administrative Code §133.20, effective January 29, 2009, sets out the procedure for submitting medical bills.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 25, 2010
   - Direct supervision by a licensed physician/healthcare provider lacking as represented on bill. Purported supervision by a licensed physician/health care provider was not of an employee. The health care provider who provided or supervised the services must submit his or her own bill.
   - 892-Per DWC rules 133.10, 133.20 and clean claim guide instructions for completing the CMS-1500. Professional license type, number and jurisdiction of the individual HCP who rendered the health care is required.
   - CAC-W1-Workers compensation state fee schedule adjustment.
   - CAC-4-The procedure code is inconsistent with the modifier used or a required modifier is missing.
   - CAC-16-Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (May be comprised of either the remittance advice remark code or NCPDP reject reason code).
   - 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - 732-Accurate coding is essential for reimbursement. CPT and/or modifier billed incorrectly. Services are not reimbursable as billed.
   - 892-Denied in accordance with DWC rules and/or medical fee guideline.

   Explanation of benefits dated December 8, 2010
   - Per Rule 180.24, financial disclosure not met. Direct supervision by a licensed physician/healthcare provider lacking as represented on bill. Purported supervision by a licensed physician/health care provider was not of an employee. The health care provider who provided or supervised the services must submit his or her own bill.
   - 892-Per DWC rules 133.10, 133.20 and clean claim guide instructions for completing the CMS-1500. Professional license type, number and jurisdiction of the individual HCP who rendered the health care is required.
   - 891-No additional payment after reconsideration.
   - W4-No additional reimbursement allowed after review of appeal/reconsideration.
   - CAC-B7-This provider was not certified/eligible to be paid for this procedure/service on this date of service.
   - CAC-4-The procedure code is inconsistent with the modifier used or a required modifier is missing.
   - CAC-16-Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (May be comprised of either the remittance advice remark code or NCPDP reject reason code).
   - 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.

- 732-Accurate coding is essential for reimbursement. CPT and/or modifier billed incorrectly. Services are not reimbursable as billed.
- 892-Denied in accordance with DWC rules and/or medical fee guideline.
- 896-Statutory/regulatory violation.

Issues

1. Is StatLink a healthcare provider as defined in Texas Labor Code §401.011?
2. Does a financial disclosure issue exist?
3. Does the documentation support services billed with CPT code 95920, 95822, 95925, 95822, 95926, 95904 and 95861?

Findings

1. The respondent states in the position summary that "The billing is done through Statlink, which claims to be a company that provides management and other administrative services to physician practices. Texas Mutual does not necessarily agree with this given the description of the company on its website. *See Attachment E*. It appears that StatLink itself is a health care provider under the Texas Labor Code definition in section 401.011(22)."

   Texas Labor Code §401.011(20) defines a "Health care facility" means a hospital, emergency clinic, outpatient clinic, or other facility providing health care."

   Texas Labor Code §401.011(21) defines "Health care practitioner" means:
   (A) an individual who is licensed to provide or render and provides or renders health care; or
   (B) a nonlicensed individual who provides or renders health care under the direction or supervision of a doctor."

   Texas Labor Code §401.011(22) defines "Health care provider" means a health care facility or health care practitioner.

   The Division reviewed the respondent's Attachment E, StatLink's website, which states "StatLink's processing power is interpretation, monitoring, data handling and billing of neurological tests"; "StatLink's online platform offers customers significant efficiencies over their current methods of business process management"; and "StatLink Financial is a full-service medical billing facility exclusively for our clients."

   The Division finds that the submitted documentation does not support that StatLink is a healthcare provider as defined in Texas Labor Code §401.011.

2. The respondent denied reimbursement for the disputed services based upon reason "Per Rule 180.24, financial disclosure not met".

   The requestor states in the January 26, 2011 position summary that "Dr. Proler had absolutely no obligation under DWC rules to disclose his ownership interest in StatLink because: a. StatLink, a management company, b. As a management company StatLink provides no health care services and is not a health care provider; and c. Dr. Proler refers no patients to StatLink."

   28 Texas Administrative Code §180.24(b) states " Submission of Financial Disclosure Information to the division. (1) If a health care practitioner refers an injured employee to another health care provider in which the health care practitioner, or the health care provider that employs the health care practitioner, has a financial interest, the health care practitioner shall file a disclosure with the division within 30 days of the date the first referral is made unless the disclosure was previously made. This annual disclosure shall be filed for each health care provider to whom an injured employee is referred and shall include the information in paragraph (2) of this subsection."

   Because StatLink does not meet the definition of healthcare provider per in Texas Labor Code §401.011, the Division finds that a financial disclosure issue does not exist.

3. According to the explanation of benefits, CPT codes 95920, 95925, 95822, 95926, 95904 and 95861 were denied reimbursement based upon reason code "225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information"; "CAC-16-Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised or either the remittance advice remark code or NCPDP reject reason code)"; "CAC-4-The procedure code is inconsistent with the modifier used or a required modifier is missing"; and "732-Accurate coding is essential for reimbursement. CPT and/or modifier billed incorrectly. Services are not reimbursable as billed".

   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."

A review of the submitted documentation indicates that the February 4, 2010 Intraopertive Neurophysiology Report was signed by Meyer Proler, MD. Dr. Proler wrote "The neruophysiological monitoring of the surgical procedure was performed under continuous real time observation and supervision by a clinical neurophysiologist." Dr. Proler further wrote that "This is an interpretation of Med DataLink database record…" Therefore, Dr. Proler provided the professional services of the procedure.

A review of the submitted medical bill indicates that Dr. Proler billed for the whole procedure. The documentation does not support that Dr. Proler performed the whole procedure for the disputed services. Therefore, the documentation does not support the level of service billed. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that 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

		9/21/2012
Signature	Medical Fee Dispute Resolution Officer	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.