



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

PEDRO NOSNIK, MD PA

Respondent Name

LIBERTY MUTUAL FIRE INSURANCE

MFDR Tracking Number

M4-11-3020-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

MAY 9, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Medicare guidelines showing CPT 95903 is billable 8 per year, Dr. Pedro Nosnik billed 4 units, still seeking additional payment for 2 more units."

Amount in Dispute: \$187.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill and documentation attached to the medical dispute have been re-reviewed and our position remains unchanged. Our rationale is as follows: CPT Appendix I indicates that the maximum number of studies for this CPT is 4 with the exception of Bilateral Tarsal Tunnel Syndrome which is 5. I have enclosed the CPT Guidelines for the maximum number of studies."

Response Submitted By: Liberty Mutual Insurance Group

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 16, 2010	CPT Code 95903 (X6) Nerve Conduction Studies - Motor	\$187.60	\$182.98

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.600, effective May 2, 2006, requires preauthorization for specific treatments and services.
- 28 Texas Administrative Code §137.100, effective January 18, 2007, sets out the use of the treatment guidelines.
- 28 Texas Administrative Code §134.203, effective March 1, 2008, 33 Texas Register 364, sets the reimbursement guidelines for the disputed service.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W1-Workers compensation state fee schedule adjustment.
 - 17-Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.
 - U899-Procedure has exceeded the maximum allowed units of service.

Issues

1. Is the value of CPT code 95903 included in the value of another procedure billed on the disputed date?
2. Was the respondent's denial of reimbursement based upon "U899" supported?
3. Is the requestor entitled to additional reimbursement for code 95903?

Findings

1. Per 28 Texas Administrative Code §134.203(b)(1) "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: 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."

On the disputed dates of service, the requestor billed CPT codes 99244, 95861, 95903 and 95904.

According to the CCI edits, CPT code 95903 is not a component of any of the other codes billed on the disputed date. Reimbursement in accordance with the Division's fee guideline is recommended.

2. According to the submitted explanation of benefits, the respondent paid \$366.08 for CPT Code 95903 based upon reason code "U899."

The respondent is relying on Medicare Utilization Guidelines to manage the claimant's care. 28 Texas Administrative Code §134.203(a)(7) states "Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program. Independent Review Organization (IRO) decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies."

The Division relies on the treating doctor to manage and or recommend the claimant's care. In addition, the Division sets out the treatment guidelines in 28 Texas Administrative Code §137.100, as well as a process for preauthorizing specific treatments and services in §134.600. The Division finds that the respondent's denial based upon reason code "U899" is not supported.

3. Per 28 Texas Administrative Code §134.203(c)(1)(2), "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. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

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

The 2010 DWC conversion factor for this service is 54.32.

Review of Box 32 on the CMS-1500 the services were rendered in Plano, Texas; therefore, the Medicare

participating amount is based upon the locality of "Rest of Texas".

The Medicare conversion factor is 36.8729.

The Medicare participating amount for code 95903 is \$62.12.

Using the above formula, the MAR is \$91.51. The requestor billed for 6 units; therefore, \$91.51 X 6 = \$549.06
The respondent paid \$366.08. As a result, the requestor is due an additional reimbursement of \$182.98.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$182.98.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$182.98 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	06/18/2014 Date
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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.