



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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

DOWNTOWN PERFORMANCE MEDICAL CENTER

Respondent Name

ILLINOIS NATIONAL INSURANCE COMPANY

MFDR Tracking Number

M4-11-3119-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

May 13, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Services were provided to this patient as well as documented in the report."

Amount in Dispute: \$287.32

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier made a payment . . . and denied procedure codes 95831 and 95851 59 because these services are/were not documented in the 12/29/2010 medical record. The doctor is requesting additional payment for range of motion and manual muscle testing but the medical record (EMG/NCV) does not support nor logically relate to EMG/NCV's. . . . The preauthorization request that was submitted to the carrier does not refer to manual muscle testing or range of motion."

Response Submitted by: AIG Claim Services

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|-------------------|--|-------------------|------------|
| December 29, 2010 | Procedure Codes: 95831, 95851, A4558, A4215, A4556 | \$287.32 | \$0.00 |

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 medical fee disputes.
2. 28 Texas Administrative Code §133.4 requires written notification to health care providers regarding contractual agreements for informal and voluntary networks.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 1 – (B12) Services not documented in patients’ medical record.
 - 4 – (97) The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
 - 1 – This charge was not reflected in the report as one of the procedures/services performed. (VF03)
 - 5 – This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed. (B291).

Issues

1. Did the response address new denial reasons or raise new defenses that were not presented to the requestor prior to the filing of the request for medical fee dispute resolution?
2. Are the disputed services subject to a contract?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent’s position statement contends that: “The preauthorization request that was submitted to the carrier does not refer to manual muscle testing or range of motion.” 28 Texas Administrative Code §133.307(d)(2)(F) requires that “The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.” Review of the explanations of benefits finds no denial code or explanation related to preauthorization. No documentation was found to support that the insurance carrier presented the above denial reason to the requestor prior to the filing of the request for medical fee dispute resolution. Consequently, the insurance carrier has waived the right to raise this new denial reason or defense and it may not be considered in this review.
2. Review of the submitted explanations of benefits finds additional payment notations that state “Any reduction is in accordance with your Aetna contract. Aetna is part of the Coventry network through Aetna’s leased arrangement with Coventry.” Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute. The submitted documentation does not include a copy of the alleged contract(s) that the respondent seeks to apply. No documentation was found to support that the insurance carrier, Illinois National Insurance Company, is a party to the alleged contract between the health care provider and the alleged informal or voluntary network. No documentation was found to support that the insurance carrier had been granted access to the health care provider’s contracted fee arrangement with the alleged network during the period that the disputed services were rendered. No documentation was found to support that the health care provider had been given notice, in the time and manner required by 28 Texas Administrative Code §133.4, that the insurance carrier had been granted access to the health care provider’s contracted fee arrangement at the time the disputed services were rendered. The Division therefore concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
3. This dispute relates to professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.203(b)(1), which requires that for coding, billing, reporting, and reimbursement of professional medical services, Texas workers’ compensation system participants shall apply “Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers . . . 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 information finds that:

- Procedure code 95831 (2 units) denotes “manual muscle testing, with report, each extremity (excluding hand) or trunk.” The insurance carrier reduced payment for the disputed service with claim adjustment explanations “(B12) Services not documented in patients’ medical record” and “This charge was not reflected in the report as one of the procedures/services performed. (VF03).” The respondent states that “services are/were not documented in the 12/29/2010 medical record. The doctor is requesting additional payment for range of motion and manual muscle testing but the medical record (EMG/NCV) does not

support nor logically relate to EMG/NCV's." Review of the submitted medical documentation finds that this service is not documented. Nor did the requestor submit a copy of the manual muscle testing report for review. The respondent's denial reason is supported. No additional reimbursement can be recommended.

- Per Medicare's CCI edit payment policy, procedure code 95851 may not be reported with procedure code 95831 billed on the same date of service. A modifier is not allowed to distinguish separate services. Separate reimbursement cannot be recommended.
- Procedure code A4558 represents conductive gel or paste. This procedure code has a status indicator of P, which designates a bundled or excluded code. Per Medicare payment policy, payment for supplies that are incidental to a physician service is bundled into the payment for the physician service to which it is incident. Separate payment cannot be recommended.
- Procedure code A4215 represents a sterile needle. This procedure code has a status indicator of X, which designates items and services subject to statutory exclusion. Per Medicare payment policy, payment for supplies that are incidental to a physician service is bundled into the payment for the physician service to which it is incident. Separate payment cannot be recommended.
- Procedure code A4556 represents a pair of electrodes. This procedure code has a status indicator of P, which designates a bundled or excluded code. Per Medicare payment policy, payment for supplies that are incidental to a physician service is bundled into the payment for the physician service to which it is incident. Separate payment cannot be 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

| | | |
|-----------|--|--------------|
| _____ | Grayson Richardson | May 29, 2015 |
| 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 MFDR 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 this 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.