**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**

JAMES WEISS MD
3100 TIMMONS LANE NO 250
HOUSTON TX 77027

**Respondent Name**
Metropolitan Transit Authority

**Carrier's Austin Representative Box**
Box Number 19

**MFDR Tracking Number**
M4-11-3714-01

**MFDR Date Received**
June 27, 2011

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Carrier failed to properly this designated doctors referral for diagnostic testing to determine the MMI/IR. The purpose of the office consult is to review the medical records and to interview patient and explain procedures. Also the CPT code 95903 is to determine is there is any thoracic outlet outlet syndrome and therefore shouldnt be bundled with CPT code 95900."

**Amount in Dispute:** $754.86

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Please see the detailed analysis by STARR Comprehensive Solutions, Inc., dated 7/7/11, supporting the billing reductions. The Texas Labor Code requires reimbursement for all medical expenses to be fair and reasonable and be designed to ensure the quality of medical care and to achieve effective medical cost control. TEX. LABOR CODE Section 413.011(d). Further, the carrier challenges whether the charges are consistent with applicable fee guidelines."

**Response Submitted by:** Flahive Ogden & Latson

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| November 11, 2010 | Professional Services | $754.86 | $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 medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 150 – Payment adjusted because the payer deems the information submitted does not support this level of

service. Note: There is no documentation that evaluation/consult was requested by the DD. The DD examination provides the components necessary for evaluation and management. Medical necessity for consult/office visit is not established.

- 97 – Payment included in the allowance for another service/procedure. Note: Supplies/electrodes are global of the reimbursement for the EMB/NCV.
- 193 – Original payment decision is being maintained. This claim was process properly the first time.
- W1 – Workers Compensation State Fee Schedule Adjustment
- Note – 150 - Documentation submitted does not support the medical necessity for a second motor test with F-wave study.

**Issues**

1. Did the requestor meet the requirements of 28 Texas Administrative Code §134.203?
2. Did the carrier support the denial of the disputed services?
3. Is the requestor entitled to reimbursement?

**Findings**

1. The carrier denied the disputed service 99203 as, 150 – "Payment adjusted because the payer deems the information submitted does not support this level of service. There is no documentation that evaluation/consult was requested by the DD. The DD examination provides the components necessary for evaluation and management. Medical necessity for consult/office visit is not established." Review of submitted documentation finds:
    a. Division of Workers' Compensation EES-14 that lists Dr. Howard L Dillard as designated doctor
    b. Dr. Michael Lee Blackwell as treating doctor
    c. Purpose of Examination 1) to determine maximum medical improvement (MMI), 2) Determine impairment rating, 3) Determine the ability of the employee to return to work

    There is no documentation of a referral to the requestor, Dr. James D Weiss, to determine MMI/IR as stated by the requestor. Carrier's denial is supported.

2. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "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;… and other payment policies in effect on the date a service is provided…" The carrier denied the disputed service 95903 as 150 – "Documentation submitted does not support the medical necessity for a second motor test with F-wave study". The *NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICARE SERVICES*, Chapter 11, Section(L)(6), states, "The NCCI edit with column one CPT code 95903 (Motor nerve conduction studies with F-wave study, each nerve) and column two CPT code 95900 (Motor nerve conduction studies without F-wave study, each nerve) is often bypassed by utilizing modifier 59. Use of modifier 59 with the column two CPT code 95900 of this NCCI edit is appropriate only if the two procedures are performed on different nerves or at separate patient encounters." Therefore, the carrier's denial is supported.

3. 28 Texas Administrative Code §134.203(c) is the applicable division fee schedule for calculation of the maximum allowable reimbursement for the services in dispute. For services in 2010, the maximum allowable reimbursement = (TDI-DWC Conversion Factor / Medicare CONV FACT ) x Non-Facility Price or;

| Code | MAR Calculation | Units | Allowable |
|---|---|---|---|
| 99203 | Carriers' denial supported | 1 | $0.00 |
| 95860 | (54.32 / 36.8729) x 85.10 | 1 | $125.37 |
| 95900 | (54.32 / 36.8729) x 55.58 = 81.88 x 6 units | 6 | $491.27 |
| 95903 | CCI edit denial | 6 | $0.00 |
| 95904 | (54.32 / 36.8729) = 48.91 x 6 units | 6 | $432.31 |
| A4556 | Bundled code, not separately payable | 1 | $0.00 |
| | | Total | $1,048.95 |

The total allowable for the disputed services eligible for review is $1,048.95. The carrier paid $1,048.95. No additional payment can 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**

| | | |
|---|---|---|
| | | February , 2014 |
| 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**.