



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

STEVE SACKS, MD

**Respondent Name**

INDEMNITY INSURANCE CO OF NORTH AMERICA

**MFDR Tracking Number**

M4-14-1474-01

**Carrier's Austin Representative**

Box Number 15

**MFDR Date Received**

JANUARY 27, 2014

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The claim was billed per Medical Fee Guideline conversion factors as established in 28 Texas Administrative Code 134.203."

**Amount in Dispute:** \$763.07

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "CPT codes 95886 and A4556 were adjusted to reflect applicable fee guideline MAR amounts. The office visit under CPT 99205 was denied...The NCV study billed under CPT 95912 was also denied entirely because the documentation did not support the level of service. CPT 95912 was billed for 11 to 12 studies, when the documentation only showed 10 were performed."

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

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 3, 2013	CPT Code 99205 New Patient Office Visit	\$278.95	\$0.00
	CPT Code 95886 (X3) Needle EMG	\$36.90	\$0.00
	CPT Code 95912 Nerve Conduction Studies (11-12)	\$438.66	\$0.00
	HCPCS Code A4556	\$8.56	\$0.00
TOTAL		\$763.07	\$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, effective March 1, 2008, 33 *Texas Register* 364, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 15- (150) – Payer deems the information submitted does not support this level of service.
  - B1-(B12)- Services not documented in patients' medical records.
  - W1-Workers compensation state fee schedule adjustment.
  - BL-After review of the bill and the medical record, this service is best described by code 99204, submitted documentation did not meet the key components required for 99205.

**Issues**

1. Does the documentation support billing CPT code 99205?
2. Does the documentation support billing CPT code 95912?
3. Is the requestor entitled to additional reimbursement for CPT code 95886?
4. Is the requestor entitled to additional reimbursement for HCPCS code A4556?

**Findings**

1. According to the explanation of benefits, the respondent denied reimbursement for code 99205 based upon the documentation does not support the level of service 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."

28 Texas Administrative Code §134.203 (b)(1) states "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; 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."

The American Medical Association Current Procedural Terminology (CPT) defines code 99205 as "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family."

A review of the submitted medical records does not support the level of service billed under CPT code 99205. As a result, reimbursement is not recommended.

2. According to the explanation of benefits, the respondent denied reimbursement for code 95912 based upon the services were not documented.

CPT code 95912 is defined as a 11-12 nerve conduction studies. A review of the submitted medical report supports 10 studies; therefore, the requestor did not support billing CPT code 95912. As a result, reimbursement is not recommended.

3. The issue in dispute is whether the requestor is due additional reimbursement for CPT code 95886?

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 2013 DWC conversion factor for this service is 55.3.

The Medicare Conversion Factor is 34.023

Review of Box 32 on the CMS-1500 the services were rendered in zip code 78475, which is located in Corpus Christi, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for “Rest of Texas”.

The Medicare participating amount for code 95886 is \$79.25

Using the above formula, the Division finds the MAR for code 95886 is \$128.81. The requestor billed for three (3) units; therefore, \$128.81 X 3 = \$386.43. The respondent paid \$386.46. As a result, reimbursement of \$0.00 is recommended.

4. 28 Texas Administrative Code §134.203(d) states “The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:  
(1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule.”

According to the DMEPOS fee schedule, HCPCS code A4556 has a total allowable of \$13.15 for Texas. Per 28 Texas Administrative Code §134.203(d), the MAR is \$16.43. The respondent paid \$16.44. As a result, reimbursement of \$0.00 is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due for the specified services. 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

\_\_\_\_\_  
12/04/2014

### **YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).

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