



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

STEVE SACKS, MD

Respondent Name

MIDDLESEX INSURANCE CO

MFDR Tracking Number

M4-14-1699-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

FEBRUARY 10, 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: \$759.73

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT 99203 09/25/2013 – The provider was issued payment in the amount of \$176.14...CPT 95886 09/25/2013 –it was noted that the provider billed for 3 extremities of EMG but only 2 extremities (lower left and lower right) were documented within the treatment notes...the provider was issued payment in the amount of \$276.22...CPT 95913 09/25/2013 – No payment was issued to the provider for this CPT code as the documentation doesn't support the CPT code 95913 as billed... CPT A4556 09/25/2013 – Provider billed \$25.00 for electrodes this line item was denied as the supply is included as part of the payment for EMG testing CPT 95886. Supplies or material normally required to complete the procedure should not be billed separately."

Response Submitted by: Coventry

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 25, 2013	CPT Code 99203 New Patient Office Visit	\$192.97	\$0.00
	CPT Code 95886 (X3) Needle EMG	\$1.57	\$0.00
	CPT Code 95913 Nerve Conduction Studies (13 or more)	\$540.19	\$0.00
	HCPCS Code A4556 Electrodes	\$25.00	\$0.00
TOTAL		\$759.73	\$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:
 - W1-Workers compensation state fee schedule adjustment.
 - 45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
 - B12-Services not documented in patients' medical records.
 - 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
 - P300-The amount paid reflects a fee schedule reduction.
 - Z710-The charge for this procedure exceeds the fee schedule allowance.
 - V093-Clinical validation reduction based upon review of documentation submitted.
 - V298-Documentation on the CMS1500 or UB04 is not supported by the information in the medical record.
 - V163-Per CPT guidelines, supplies or materials normally required to complete the procedure or service should not be billed separately.
 - W3-Request for reconsideration.
 - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is the requestor due additional reimbursement for CPT code 99203?
2. Does the documentation support billing CPT code 95886 (X3)? Is the requestor entitled to additional reimbursement for CPT code 95886?
3. Does the documentation support billing CPT code 95913?
4. Is the benefit for HCPCS code A4556 included in the benefit of another service billed on the disputed date? Is the requestor entitled to reimbursement for HCPCS code A4556?

Findings

1. According to the submitted explanation of benefits, the respondent paid for the disputed office visit based upon reason code "W1".

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."

The American Medical Association Current Procedural Terminology (CPT) defines code 99203 as "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low 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 severity. Typically, 30 minutes are spent face-to-face with the patient and/or family."

To determine if the requestor is due additional reimbursement for CPT code 99203, the Division refers to 28 Texas Administrative Code §134.203(c)(1)(2), which states "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 77042, which is located in Houston, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for “Houston, Texas”.

The Medicare participating amount for code 99203 is \$108.37.

Using the above formula, the Division finds the MAR for code 99203 is \$176.14. The respondent paid \$176.14. As a result, reimbursement of \$0.00 is recommended

2. The respondent reduced payment for CPT code 95886 based upon reason code “B12”. The respondent states in the position summary that “it was noted that the provider billed for 3 extremities of EMG but only 2 extremities (lower left and lower right) were documented within the treatment notes.”

CPT code 95886 is defined as “Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure).”

A review of the submitted medical report finds that the documentation does not support the third EMG billed; therefore, reimbursement for the third EMG is not recommended.

To determine if the requestor is due additional reimbursement for the documented CPT code 95886, the Division refers to 28 Texas Administrative Code §134.203(c)(1)(2).

The Medicare participating amount for code 95886 is \$84.97.

Using the above formula, the Division finds the MAR for code 95886 (X2) \$276.22. The respondent paid \$276.22. As a result, reimbursement of \$0.00 is recommended.

3. On the disputed date of service, the requestor also billed CPT code 95913 defined as 13 or more nerve conduction studies. The submitted explanation of benefits indicate that the service was denied payment based upon reason “B12”.

A review of the submitted medical report indicates the provider performed 11 studies; therefore, the requestor did not support billing of CPT code 95913. As a result, reimbursement is not recommended.

4. According to the explanation of benefits, the respondent denied reimbursement for HCPCS code A4556 based upon reason code “97.”

HCPCS Code A4556 is defined as “Electrodes (e.g., apnea monitor), per pair.”

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.”

Per Medicare policy, if HCPCS codes A4556 is incidental to the physician service, it is not separately payable. A review of the submitted documentation does not support a separate service. 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 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

12/05/2014

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.