



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

METROPOLITAN TRANSIT AUTHORITY

MFDR Tracking Number

M4-14-1759-01

Carrier's Austin Representative

Box Number 29

MFDR Date Received

FEBRUARY 18, 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: \$291.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Respondent's Supplemental Position Summary dated March 19, 2014: "Carrier maintains its position as outlined in the original response."

Responses Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 16, 2013	CPT Code 99203 New Patient Office Visit	\$16.83	\$0.00
	CPT Code 95886 (X2) Needle EMG	\$15.74	\$0.00
	CPT Code 95913 Nerve Conduction Studies (13 or more)	\$233.93	\$0.00
	HCPCS Code A4556 Electrodes	\$25.00	\$0.00
TOTAL		\$291.50	\$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 §127.10, effective September 1, 2012 sets out the procedures for designated doctor examinations.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W1-Workers compensation state fee schedule adjustment.
 - 97-Payment is included in the allowance for another service/procedure.
 - 165-Payment denied/reduced for absence of, or exceeded referral.
 - 165-The office visit exceeds the referral. The designated doctor referred the patient for EMG/NCV only.
 - 97-Supplies/electrodes are global of the reimbursement for the EMG/NCV.
 - 193-Original payment decision is being maintained.
 - W3- Additional payment made on reconsideration.
 - P12-Workers compensation jurisdictional fee schedule adjustment.

Issues

1. Does the documentation support referral from Designated Doctor for office visit?
2. Is the requestor entitled to additional reimbursement for CPT codes 95886 and 95913?
3. 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 explanation of benefits, the respondent denied reimbursement for the office visit based upon reason code "165."

28 Texas Administrative Code §127.10(c) states "The designated doctor shall perform additional testing when necessary to resolve the issue in question. The designated doctor shall also refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question and the designated doctor is not qualified to fully resolve the issue in question."

The requestor's report indicates that "[Claimant] presents today for an EMG/NCV of the bilateral upper extremities. She is referred by Bobby M. Hollander, D.C., as part of a Designated Doctor Examination." The documentation does not support Dr. Hollander requested a separate evaluation and management service; therefore, the respondent's denial based upon reason "165" is supported. As a result, reimbursement is not recommended.

2. The issue in dispute is whether the requestor is due additional reimbursement for CPT codes 95213 and 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 77042, which is located in

Houston, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for Houston, Texas.

Using the above formula, the Division finds the following:

Code	Medicare Participating Amount	Maximum Allowable	Carrier Paid	Due
95913	\$303.35	\$493.06	\$493.06	\$0.00
95886	\$84.97 (X2)	\$276.22	\$276.22	\$0.00

3. 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.