



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

Donald M McPhaul

Respondent Name

Liberty Mutual Insurance Co

MFDR Tracking Number

M4-14-1477-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

January 27, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am requesting that this injured workers claim be reviewed for additional monies per Rule 133.250."

Amount in Dispute: \$748.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Liberty Mutual believes that Donald Martin McPhaul has been appropriately reimbursed for services rendered to (claimant) for the 11/13/2013 dated(s) of service."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 13, 2013	99203, 95886, 95911, A4556	\$748.00	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - Z710 – The charge for this procedure exceeds the fee schedule allowance.
 - U058 – Procedure code should not be billed without appropriate primary procedure
 - X133 – This charge was not reflected in the report as one of the procedures or services performed
 - B291 – This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed
 - 193 – Original payment decision is being maintained

Issues

1. Was the level of service supported by documentation?
2. Did the requestor support additional payment is due?
3. Is the requestor entitled to reimbursement?

Findings

1. The carrier reduced the disputed evaluation and management visit as, Z710 – “The charge for this procedure exceeds the fee schedule allowance.” 28 Texas Administrative Code §134.203(c) 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 (current year conversion factor).” The calculation of the maximum allowable reimbursement is calculated as;
 - Procedure code 99203, service date November 13, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 1.42 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 1.43278. The practice expense (PE) RVU of 1.62 multiplied by the PE GPCI of 1.002 is 1.62324. The malpractice RVU of 0.14 multiplied by the malpractice GPCI of 0.923 is 0.12922. The sum of 3.18524 is multiplied by the Division conversion factor of \$55.30 for a MAR of \$176.14.

2. The carrier denied CPT code 95911 as, X133 – “This charge was not reflected in the report as one of the procedures or services performed.” 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 American Medical Association (AMA) CPT code description for 95911 is defined as; “Nerve conduction studies 9-10 studies”. Electromyography Report dated November 11, 2013, shows 8 studies. Per CMS Local Coverage Determination (LCD) L32723 found at www.novitas.com, “Each descriptor (code) from codes 95907, 95908, 95909, 95910, 95911, 95912, and 95913 can be reimbursed only once per nerve, or named branch of a nerve, regardless of the number of sites tested or the number of methods used on that nerve.” The carrier’s denial is supported.

The carrier denied CPT code 95886 as U058 – “Procedure code should not be billed without appropriate primary procedure.” The CPT code 95886 is classified as an “add-on” code and is associated with primary procedure. This code must never be reported as a standalone code. No separate payment can be recommended.

The carrier denied CPT code A4556 as B291 – “This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed.” Code A4556 is a bundled code and not payable separately. No separate payment can be recommended.

3. The total allowable reimbursement for the services in dispute is \$176.14. This amount less the amount previously paid by the insurance carrier of \$176.00 leaves a balance of \$.014. No additional amount can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has 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

Signature

Medical Fee Dispute Resolution Officer

November , 2014
Date

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.