



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

New Hampshire Insurance Co

MFDR Tracking Number

M4-14-1840-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

February 21, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please note from the attached testing results & supporting documentation that all components for this claim were performed and billed appropriately using the TDI-DWC Fee Guidelines and should not be reduced."

Amount in Dispute: \$369.37

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received however no position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 26, 2013	99205, 95886, 95912, A4556	\$369.37	\$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:
 - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
 - 15 – 150 payer deems the information submitted does not support this level of service

Issues

- Did the requestor support the level of service submitted on the medical claim?
- Is the requestor entitled to reimbursement?

Findings

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged, received on March 3, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.
2. The requestor denied the disputed service as, 16 – "Claim/service lacks information or has submission/billing error(s) which is needed for adjudication and 150 – Payer deems the information submitted does not support this level of service." 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..." Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient. The American Medical Association (AMA) CPT code description for 99205 states, "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 moderate 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."

Documentation of the Comprehensive History

- History of Present Illness (HPI) consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions. Documentation found listed one chronic condition thus not meeting this component.
- Review of Systems (ROS) inquires about the system (s) directly related to the problem(s) plus additional body systems. At least ten organ systems must be reviewed. Documentation found listed four systems, this component was not met.
- Past Family, and/or Social History (PFSH) require a review of two or all history areas, at least one specific item from each history areas to be documented. The documentation found listed one area. This component was not met.

Documentation of a Comprehensive Examination:

- Requires at least nine organ systems to be documented, with at least two elements listed per system. The documentation found listed eight body/organ systems. This component was not met.

Documentation requirements to support level of service was not found, the Carrier's denial is supported no additional payment can be recommended.

3. Per 28 Texas Administrative Code §134.203(c) states in pertinent part "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 (date of service yearly conversion factor). The services in dispute will be calculated as follows;
 - Procedure code 95886, service date April 26, 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 0.7 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.7063. The practice expense (PE) RVU of 1.76 multiplied by the PE GPCI of 1.002 is 1.76352. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.923 is 0.02769. The sum of 2.49751 is multiplied by the Division conversion factor of \$55.30 for a MAR of \$138.11 at 2 units is \$276.22. Based on the requestor's DWC-60 this amount was paid. No additional payment is recommended.
 - Procedure code 95912, service date April 26, 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 3

multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 3.027. The practice expense (PE) RVU of 4.49 multiplied by the PE GPCI of 1.002 is 4.49898. The malpractice RVU of 0.18 multiplied by the malpractice GPCI of 0.923 is 0.16614. The sum of 7.69212 is multiplied by the Division conversion factor of \$55.30 for a MAR of \$425.37. Based on the requestor's DWC-60 this amount was paid. No additional payment is recommended.

- Procedure code A4556, service date April 26, 2013, represents a supply or equipment with reimbursement determined per §134.203(d). The fee listed for this code in the Medicare DMEPOS fee schedule is \$13.15. 125% of this amount is \$16.44. Based on the requestor's DWC-60 this amount was paid. No additional payment is recommended.

4. The total allowable reimbursement for the services in dispute is \$718.03. This amount less the amount previously paid by the insurance carrier of \$718.03 leaves an amount due to the requestor of \$0.00.

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

Signature

Medical Fee Dispute Resolution Officer

December , 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.