



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

FIRST LIBERTY INSURANCE CORP

MFDR Tracking Number

M4-14-2732-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

MAY 8, 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: \$817.26

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill and documentation attached to the medical dispute have been re-reviewed and our position remains unchanged."

Response Submitted By: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 21, 2014	CPT Code 99203 New Patient Office Visit	\$23.61	\$0.00
	CPT Code 95886 (X2) Needle EMG	\$302.62	\$0.00
	CPT Code 95913 Nerve Conduction Studies (13 or more)	\$466.03	\$0.00
	HCPCS Code A4556 Electrodes	\$25.00	\$0.00
TOTAL		\$817.26	\$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, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.

3. 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.
 - B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.
 - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - 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.
 - X598-Calim has been re-evaluated based on additional documentation submitted; no separate payment allowed.

Issues

1. Is the requestor due additional reimbursement for CPT code 99203?
2. Does the documentation support billing 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 "Z710".

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 (AMA) 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©(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 2014 DWC conversion factor for this service is 55.75.

The Medicare Conversion Factor is 35.8228

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 \$108.82.

Using the above formula, the Division finds the MAR for code 99203 is \$169.35. The respondent paid \$169.36. As a result, reimbursement of \$0.00 is recommended

2. The respondent denied reimbursement for code 95886 based upon reason code "X133".
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)."
The requestor noted in the report that "EMG: Needle study was not done because of absence of discernable need in view of nature and location of injury." The Division finds that the respondent supported denial of reimbursement based upon "X133". As a result, reimbursement is not recommended.
3. Based upon the submitted explanation of benefits, the respondent denied reimbursement for code 95913 based upon reason code "X133."
CPT code 95913 is defined as "Nerve conduction studies; 13 or more studies."
The AMA guideline for Neurology and Neuromuscular Procedures states "For the purposes of coding, a single conduction study is defined as a sensory conduction test, a motor conduction test with an F-wave or without an F wave test, or an H-reflex test. Each type of nerve conduction study is counted only once when multiple sites on the same nerve are stimulated or recorded."
A review of the submitted medical report finds that the requestor did not support the number of studies performed for 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 "B291."
HCPCS Code A4556 is defined as "Electrodes (e.g., apnea monitor), per pair."
Per Medicare guideline 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 per 28 Texas Administrative Code §134.203(a)(5).

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

02/03/2015

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.