



**TEXAS DEPARTMENT OF INSURANCE**

**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**

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**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**GENERAL INFORMATION**

**Requestor Name**

Susan Van De Water MD

**Respondent Name**

Liberty Mutual Insurance

**MFDR Tracking Number**

M4-15-2178-01

**Carrier's Austin Representative**

Box Number 01

**MFDR Date Received**

March 18, 2015

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "We submitted a request for reconsideration to Liberty Mutual on 2-5-2015, this request was in response to a \$162.22 reduction of the \$752.61 for the EMG performed on 12-19-2014. Unfortunately our request was denied and we are seeking the balance owed to us."

**Amount in Dispute:** \$162.22

**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

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 19, 2014	99204, 95886, 95909, A4556	\$162.22	\$0.00

**FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - P12 – Procedure code not separately payable under Medicare and-or fee schedule guidelines
  - 150 – Billed procedure is not documented in the submitted records
  - 193 – Original payment decision is being maintained

## Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

## Findings

1. The insurance carrier denied disputed service Procedure Code 95886 with claim adjustment reason codes 150 – "Billed procedure is not documented in the submitted records." Review of the submitted medical records finds;
  - Electromyography (EMG) Report dated 12-19-2014 shows all testing to have been done on left upper extremity
  - The submitted code has a short description "95886 - Needle electromyography, each extremity,"

As the medical record supports only one extremity tested, the Carrier's denial is supported.

2. 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 remaining services in dispute will be calculated as follows:
  - Procedure code 99204, service date December 19, 2014, 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 2.43 multiplied by the geographic practice cost index (GPCI) for work of 1 is 2.43. The practice expense (PE) RVU of 1.99 multiplied by the PE GPCI of 0.916 is 1.82284. The malpractice RVU of 0.22 multiplied by the malpractice GPCI of 0.816 is 0.17952. The sum of 4.43236 is multiplied by the Division conversion factor of \$55.75 for a MAR of \$247.10.
  - Procedure code 95886, service date December 19, 2014, 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 0.86 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.86. The practice expense (PE) RVU of 1.67 multiplied by the PE GPCI of 0.916 is 1.52972. The malpractice RVU of 0.04 multiplied by the malpractice GPCI of 0.816 is 0.03264. The sum of 2.42236 is multiplied by the Division conversion factor of \$55.75 for a MAR of \$135.05.
  - Procedure code 95909, service date December 19, 2014, 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 1.5 multiplied by the geographic practice cost index (GPCI) for work of 1 is 1.5. The practice expense (PE) RVU of 2.36 multiplied by the PE GPCI of 0.916 is 2.16176. The malpractice RVU of 0.09 multiplied by the malpractice GPCI of 0.816 is 0.07344. The sum of 3.7352 is multiplied by the Division conversion factor of \$55.75 for a MAR of \$208.24.
  - Procedure code A4556 is a bundled code. No separate payment can be recommended.

3. The total allowable reimbursement for the services in dispute is \$590.39. This amount less the amount previously paid by the insurance carrier of \$590.39 leaves an amount due to the requestor of \$0.00. No additional reimbursement can be recommended.

**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

\_\_\_\_\_  
Date

May , 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, 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 MFDR 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.**