



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

James Weiss MD

Respondent Name

Ace American Insurance Co

MFDR Tracking Number

M4-15-2186-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

March 18, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to Gallagher Bassett on 11-12-2014, this request was in response to \$770.42 reduction of the \$1058.80 for the EMG performed on 6-26-2014. Unfortunately our request was denied and we are seeking the balance owed to us."

Amount in Dispute: \$770.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...no additional reimbursement should be ordered to Requestor for the dates of service in dispute."

Response Submitted by: Downs ♦ Stanford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 26, 2014	99204, 95886, 95913, A4556	\$770.42	\$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:
 - 150 – Payer deems the information submitted does not support this level of service
 - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

- 112 – Service not furnished directly to the patient and/or not documented

Issues

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

Findings

1. The insurance carrier denied submitted code 99204 with the claim adjustment reason code “150 – Payer deems the information submitted does not support this level of service” and code A4556 as “97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated and 95913 as “112 – Service not furnished directly to the patient and/or not documented.” 28 Texas Administrative Code §134.203 (b) 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;” The 1997 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare policy a guide can be found at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf . It describes the documentation requirements for the service in dispute. Review of the documentation finds the following: Review of submitted medical documentation finds;

- a. Procedure Code 99204 has a description of, “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, 45 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 and eight elements, thus 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 two systems, this component was not met.

Past Family, and/or Social History (PFSH) requires 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 two body/organ systems: This component was not met.

- b. Procedure Code 95913 - Nerve conduction studies; 13 or more studies. Review of the submitted medical record finds. The Medicare payment policy, LCD ID, L32723, LCD Title Nerve Conduction Studies and Electromyography, states, “Nerve Conduction Studies and Electromyography. 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.** For instance, testing the ulnar nerve

at wrist, forearm, below elbow, above elbow, axilla and supraclavicular regions will all be considered as a single nerve. Motor and sensory nerve testing are considered separate tests.” Based on the above the medical record supports only 4 studies.

- c. Procedure Code A4556 is a bundled code inclusive of the primary procedure. No separate payment can be recommended.
2. 28 Texas Administrative Code §134.203(c) “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 maximum allowable reimbursement will be calculated as follows;
 - Procedure code 95886, service date June 26, 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 1.014 is 0.87204. The practice expense (PE) RVU of 1.67 multiplied by the PE GPCI of 1.004 is 1.67668. The malpractice RVU of 0.04 multiplied by the malpractice GPCI of 0.939 is 0.03756. The sum of 2.58628 is multiplied by the Division conversion factor of \$55.75 for a MAR of \$144.19 at 2 units is \$288.38.
3. The total allowable reimbursement for the services in dispute is \$288.38. This amount less the amount previously paid by the insurance carrier of \$288.38 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

		May 13, 2015
Signature	Medical Fee Dispute Resolution Officer	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, 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.