



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

STEVE SACKS, MD

Respondent Name

AMERICAN CASUALTY CO OF READING PA

MFDR Tracking Number

M4-15-2350-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

MARCH 30, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to CNA Dallas on February 2, 2015, this request was in response to a \$642.42 payment of the \$929.87 for the EMG/NCV Designated Doctor Referred performed on September 12, 2014. Unfortunately our request was denied and we are seeking the balance owed to us."

Amount in Dispute: \$287.45

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In this case the provider's documented treatment notes do not support the level of service billed CPT code 99204, therefore CPT code 99204 was denied...CPT 95886...Provider billed \$289.08 the provider was paid \$288.38...No further payment is due...CPT 95911...Provider billed \$354.89 the provider was paid \$354.04...No further payment is due...CPT A4556...Provider billed \$25.00 the provider was paid Zero."

Response Submitted by: Law Offices of Brian J. Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 12, 2014	CPT Code 99204 New Patient Office Visit	\$260.90	\$0.00
	CPT Code 95886 (X2) Needle EMG	\$0.70	\$0.00
	CPT Code 95911 Nerve Conduction Studies (9-10)	\$0.85	\$0.00
	HCPCS Code A4556 Electrodes	\$25.00	\$0.00
TOTAL		\$287.45	\$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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 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:
 - 150-Payer deems the information submitted does not support this level of service.
 - P12-Workers' compensation jurisdictional fee schedule amount.
 - 197-Precertification/authorization/notification absent.
 - 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
 - P300-The amount paid reflects a fee schedule reduction.
 - V122-CV: The level of E & M code submitted is not supported by documentation.
 - MT12-Dainagnosis code indicates severe injury.
 - XF06-Per TX rule 134.600 Pre-Auth is Required. If services have been preauthorized resubmit the bill with authorization info for reconsideration.
 - Z710-The charge for this procedure exceeds the fee schedule allowance.
 - 112-Services not furnished directly to the patient and/or not documented.
 - V292-CV: Documented procedure does not appear to match the code description of the CPT code billed.
 - V163-CV: Per CPT Guidelines, supplies or materials normally required to complete the procedure or service should not be billed separately.
 - ZV34-After review of the bill and the medical record, this service is best described by 99203. Submitted documentation did not meet the 3 key components required for 99204. Lacking a comprehensive history, a comprehensive physical examination and a medical decision making of moderate complexity.
 - 193, Z086-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - W3-Request for reconsideration.
 - Z257-CV Reconsideration: No additional allowance recommended. This bill and submitted documentation have been re-evaluated by Clinical Validation. Submitted documentation does not support an additional allowance.

Issues

1. Does a preauthorization issue exist?
2. Does the documentation support billing CPT code 99204
3. Is the requestor due additional reimbursement for CPT codes 95886 and 95911?
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. CPT codes 99204, 95886 and 95911 were initially denied reimbursement based upon a lack of preauthorization; however, upon reconsideration the respondent did not maintain the denial and issued payment for CPT codes 95886 and 95911. The office visit was denied based upon documentation did not support level of service billed. The Division finds that a preauthorization issue does not exist in this dispute.
2. According to the submitted explanation of benefits, the respondent denied payment for CPT code 99204 based upon reason codes "150" and "ZV34."

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 99204 as "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.”

The respondent contends that “A Comprehensive History –Requirement NOT met...A Comprehensive Examination –Requirement NOT met...Medical decision making of Moderate complexity-Requirement NOT met.”

The Division finds that the requestor’s documentation did not support billing CPT code 99204; therefore, reimbursement is not recommended.

- 3. According to the submitted explanation of benefits, the respondent paid CPT codes 95886 and 95911 based upon reason code “P12”.

To determine if the requestor is due additional reimbursement for CPT codes 95886 and 95911, the Division refers to 28 Texas Administrative Code §134.203(c)(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”.

Using the above formula, the Division finds the following:

Code	Medicare Participating Amount	Maximum Allowable	Carrier Paid	Due
95886	\$92.65	\$144.19 X 2 \$288.38	\$288.38	\$0.00
95911	\$227.49	\$354.04	\$354.04	\$0.00

- 4. According to the explanation of benefits, the respondent paid \$16.60 for HCPCS code A4556 based upon reason codes “97” and “V163.”.

HCPCS Code A4556 is defined as “Electrodes (e.g., apnea monitor), per pair.”

Furthermore, per Medicare guidelines, Transmittal B-03-020, effective February 28, 2003 if Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) HCPCS codes are incidental to the physician service, it is not separately payable. A review of the submitted documentation does not support a separate service to support billing HCPCS code A4556. As a result, additional reimbursement is not 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

		05/20/2015
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.