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
AHMED KHALIFA, MD

Respondent Name
AMERICAN CASUALTY CO OF READING PA

MFDR Tracking Number
M4-15-2381-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
APRIL 2, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to American Casualty Reading PA on November 17, 2014, this request was in response to a $526.58 reduction of the $797.11 for the EMG/NCV Designated Doctor Referred Exam performed on August 8, 2014. Unfortunately our request was denied and we are seeking the balance owed to us."

Amount in Dispute: $270.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The listed 'Amount Paid' for the disputed services is inaccurate. Carrier made payments in the recommended allowable amounts as directed on the Explanation of Reviews and reflected on the attached Pay History Screens…**CPT code 95886**…*We are unable to recommend an additional allowance since this claim was pain in accordance with the state's fee schedule guidelines….**CPT code 95909**…Provider billed $222.13 and provider was paid $221.60…No further payment is due on 95909 as it has been paid as per the TX state fee schedule…**CPT code A4556**…Provider billed $25.00 and provider was paid $16.60…No further payment is due on A4556 as it has been paid as per the TX state fee schedule."

Response Submitted by: Law Office of Brian J. Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 8, 2014	CPT Code 99204 New Patient Office Visit	$0.00	$0.00
	CPT Code 95886 (X2) Needle EMG	$23.40	$0.00
	CPT Code 95909 Nerve Conduction Studies (5-6)	$222.13	$0.00
	HCPCS Code A4556 Electrodes	$25.00	$0.00
TOTAL		$270.53	$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.
   - P300-The amount paid reflects a fee schedule reduction.
   - V122-CV: The level of E & M code submitted is not supported by documentation.
   - MT12-Dainagosis code indicates severe injury.
   - Z710-The charge for this procedure exceeds the fee schedule allowance.
   - 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.
   - 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.
   - U301-This item was previously submitted and reviewed with notification of decision issued to payor, provider (duplicate invoice).
   - P300-The amount paid reflects a fee schedule allowance.

Issues

1. Was the *Table of Disputed Services* completed in accordance with 28 Texas Administrative Code §133.307?
2. Is the requestor due additional reimbursement for CPT codes 95886 and 95909?
3. Is the requestor entitled to additional reimbursement for HCPCS code A4556?

Findings

1. 28 Texas Administrative Code §133.307 (c)(2)(H) requires "The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include: (H) the amount paid by the workers' compensation insurance carrier for the treatment(s) or service(s) in dispute."

   The respondent states that "The listed 'Amount Paid' for the disputed services is inaccurate. Carrier made payments in the recommended allowable amounts as directed on the Explanation of Reviews and reflected on the attached Pay History Screens."

   A review of the submitted explanation of benefits, finds that the amount paid on the *Table of Disputed Services* does not correspond to the amount paid on the explanation of benefits; therefore, the requestor did not complete the Table in accordance with 28 Texas Administrative Code §133.307(c)(2)(H).
2. According to the submitted explanation of benefits, the respondent paid CPT codes 95886 and 95909 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
95909	$142.39	$221.60	$221.60	$0.00

3. According to the explanation of benefits, the respondent paid $16.60 for HCPCS code A4556 based upon reason code “P12”.

   28 Texas Administrative Code §134.203(d)(1) states “The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:
   (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule.”

   The 2014 DMEPOS fee schedule for HCPCS code A4556 is $13.28; therefore, per 28 Texas Administrative Code §134.203(d), the MAR is $13.28 X 125% = $16.60.

   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 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

		05/27/2015
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.