



# 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**

Donald McPhaul MD

**Respondent Name**

Netherlands Insurance Co

**MFDR Tracking Number**

M4-15-2512-01

**Carrier's Austin Representative**

Box Number 01

**MFDR Date Received**

April 13, 2015

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "We submitted a request for reconsideration to America First Insurance on November 17, 2014, this request was in response to \$670.99 reduction of the \$1,025.73 for the EMG/NCV Designated Doctor Referred Exam performed on April 23, 2014. Unfortunately our request was denied and we are seeking the balance owed to us."

**Amount in Dispute:** \$670.99

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** Written acknowledgement of medical fee dispute received however, no position statement submitted.

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 23, 2014	99204, 95886, 95911, A4556	\$670.99	\$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
  - 193 – Original payment decision is being maintained
  - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged, received on April 21, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

### **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." 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](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;

- 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 three chronic conditions but no elements, thus not meeting this component.

History of present illness elements (HPI) consist of four or more elements associated with illness. Documentation found five elements. This component was met.

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 one system, this component was not met.

Past Family, and/or Social History (PFSH) require 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:

Require at least eight or more systems to be documented. The documentation found listed one body/organ systems: This component was not met.

- Procedure Code A4556 is a bundled code inclusive of the primary procedure. No separate payment can be recommended.

The Division finds the Carrier's denial is supported as the medical records presented with this dispute do not meet the documentation requirement of Rule 134.203 and Medicare payment rules do not allow for the payment of bundled services.

2. 28 Texas Administrative Code §134.20 3 (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 April 23, 2014. 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 1.013 is 1.69171. The malpractice RVU of 0.04 multiplied by the malpractice GPCI of 0.803 is 0.03212. The sum of 2.59587 is multiplied by the Division conversion factor of \$55.75 for a MAR of \$144.72 at 2 units is \$289.44.
  - Procedure code 95911, service date April 23, 2014. For this procedure, the relative value (RVU) for work of 2.5 multiplied by the geographic practice cost index (GPCI) for work of 1.014 is 2.535. The practice expense (PE) RVU of 3.66 multiplied by the PE GPCI of 1.013 is 3.70758. The malpractice RVU of 0.15 multiplied by the malpractice GPCI of 0.803 is 0.12045. The sum of 6.36303 is multiplied by the Division conversion factor of \$55.75 for a MAR of \$354.74.
3. The total allowable reimbursement for the services in dispute is \$644.18. This amount less the amount previously paid by the insurance carrier of \$644.18 leaves an amount due to the requestor of \$0.00. This amount is 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

\_\_\_\_\_  
July , 2015  
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.**