



**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**

SAFETY NATIONAL CASUALTY CORP

**MFDR Tracking Number**

M4-15-2581-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

APRIL 15, 2015

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "We submitted a request for reconsideration to Safety National Casualty Corporation on October 24, 2014, this request was in response to a \$909.16 reduction of the \$1024.85 for the EMG/NCV Designated Doctor Referred Exam performed on April 25, 2014. Unfortunately our request was denied and we are seeking the balance owed to us."

**Amount in Dispute:** \$115.69

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "CorVel did not receive a request for reconsideration for date of service 04/25/14 prior to receipt of this request."

**Response Submitted by:** Corvel

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 25, 2014	CPT Code 99204 New Patient Office Visit	\$31.85	\$0.00
	CPT Code 95886 (X2) Needle EMG	\$12.14	\$0.00
	CPT Code 95911 Nerve Conduction Studies (9-10)	\$46.70	\$0.00
	HCPCS Code A4556 Electrodes	\$25.00	\$0.00
TOTAL		\$115.69	\$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 §133.250, effective March 30, 2014 sets out the medical bill/audit process.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 234-This procedure is not paid separately.
  - RG4-Service is Incidental per Medicare Guidelines.
  - P12-Workers' Compensation State Fee Schedule Adj.

### **Issues**

1. Is disputed service, CPT code 95911, eligible for review in accordance with 28 Texas Administrative Code §133.307 and §133.250?
2. Is disputed services, CPT codes 99204, 95886 and A4556, eligible for review in accordance with 28 Texas Administrative Code §133.307 and §133.250?
3. Is the requestor due additional reimbursement for CPT codes 99204 and 95886?
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. 28 Texas Administrative Code §133.307(c)(2)(J), requires that the request shall include "a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier . . . and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250" Review of the submitted documentation finds that the requestor has not provided a copy of the medical bill(s) as originally submitted to the insurance carrier and/or as submitted to the insurance carrier for an appeal in accordance with §133.250 for CPT code 95911. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(J).

28 Texas Administrative Code §133.307(c)(2)(K), requires that the request shall include "a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider . . . or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB" Review of the submitted documentation finds that the request does not include copies of any EOBs for the disputed CPT code 95911. Nor has the requestor provided evidence of insurance carrier receipt of the request for an EOB for CPT code 95911. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(K).

28 Texas Administrative Code §133.250(i) states "If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills)."

A review of the submitted Table of Disputed Services lists CPT code 95911; however, the submitted medical bills and EOBs list 95912 not 95911. The Division finds that the requestor has not supported that code 95911 is eligible for review per 28 Texas Administrative Code §133.250 and §133.307. Therefore, this service is not eligible for medical fee dispute resolution. As a result, reimbursement cannot be recommended.

2. The respondent contends that “CorVel did not receive a request for reconsideration for date of service 04/25/14 prior to receipt of this request.”

28 Texas Administrative Code §133.307(c)(2)(K), requires that the request shall include “a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider . . . or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB” Review of the submitted documentation finds that the requestor provided evidence of insurance carrier receipt of the request for an EOB. The Division concludes that the requestor has met the requirements of §133.307(c)(2)(K).

28 Texas Administrative Code §133.250(i) states “If the health care provider is dissatisfied with the insurance carrier’s final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills).”

The Division finds that the requestor has supported that disputed services, CPT codes 99204, 95886 and A4556 are eligible for review per 28 Texas Administrative Code §133.250 and §133.307.

2. The issue in dispute is whether the requestor is due additional reimbursement for CPT codes 95886 and 99204.

To determine if the requestor is due additional reimbursement for CPT codes 95886 and 99204 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 78550 which is located in Harlingen, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for “Rest of Texas”.

Using the above formula, the Division finds the following:

Code	Medicare Participating Amount	Maximum Allowable	Carrier Paid	Due
95886	\$86.78	\$135.05 X 2 = \$270.10	\$270.10	\$0.00
99204	\$158.78	\$247.10	\$247.10	\$0.00

3. According to the explanation of benefits, the respondent denied reimbursement for HCPCS code A4556 based upon reason codes "234" and "RG4".

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

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 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**

_____	_____	06/16/2015
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.**