TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Steve Sacks MD

Respondent Name
Employers Insurance Co of Wausau

MFDR Tracking Number
M4-15-2818-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
May 1, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…this request was in response to a $236.03 reeducation of the $960.50 for the EMG performed on 5-22-14."

Amount in Dispute: $236.03

RESPONDENT'S POSITION SUMMARY

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

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 22, 2014	99204, 95886, 95911, A4556	$236.03	$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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.210 sets out the requirements of medical documentation.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - X133 – This charge was not reflected in the report as one of the procedures or services performed
   - 193 – Original payment decision is being maintained
   - 45 – (Z710) – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
   - B291 – This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed

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 May 12, 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 reimbursement
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed service 95886 units (2) with claim adjustment reason code X133 – "This charge was not reflected in the report as one of the procedures or services performed." 28 Texas Administrative Code §133.210 (b) states in pertinent part, "When submitting a medical bill for reimbursement, the health care provider shall provide required documentation in legible form…" Review of the submitted information finds;

    - Per CPT Code Description, 95886 – "Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure)" "Codes 95885 and 95886 may be reported once per extremity tested."
    - Page 4 of "Electromyography Report" only lists "L" (left) on the muscles listed or one extremity.

    The insurance carrier's denial reason is supported as only one unit of service is supported by the submitted documentation. Additional reimbursement cannot be recommended.

2. 28 Texas Administrative Code §134.203 (c) states in pertinent part, "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 annual conversion factor)."

    - Procedure code 99204, service date May 22, 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 2.43 multiplied by the geographic practice cost index (GPCI) for work of 1 is 2.43. The practice expense (PE) RVU of 1.99 multiplied by the PE GPCI of 0.916 is 1.82284. The malpractice RVU of 0.22 multiplied by the malpractice GPCI of 0.816 is 0.17952. The sum of 4.43236 is multiplied by the Division conversion factor of $55.75 for a MAR of $247.10.
    - Procedure code 95886, service date May 22, 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 is 0.86. The practice expense (PE) RVU of 1.67 multiplied by the PE GPCI of 0.916 is 1.52972. The malpractice RVU of 0.04 multiplied by the malpractice GPCI of 0.816 is 0.03264.

The sum of 2.42236 is multiplied by the Division conversion factor of $55.75 for a MAR of $135.05.

- Procedure code 95911, service date May 22, 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 2.5 multiplied by the geographic practice cost index (GPCI) for work of 1 is 2.5. The practice expense (PE) RVU of 3.66 multiplied by the PE GPCI of 0.916 is 3.35256. The malpractice RVU of 0.15 multiplied by the malpractice GPCI of 0.816 is 0.1224. The sum of 5.97496 is multiplied by the Division conversion factor of $55.75 for a MAR of $333.10.
- 28 Texas Administrative Code § 134.203(b) states in pertinent part, "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;" Procedure code A4556, service date May 22, 2014, has a status code of P – "Bundled / Excluded Code." No additional payment can be recommended.

3. The total allowable reimbursement for the services in dispute is $715.25. This amount less the amount previously paid by the insurance carrier of $715.25 leaves an amount due

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

		July , 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.