



# 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**

OLD REPUBLIC GENERAL INSURANCE

**MFDR Tracking Number**

M4-15-3281-01

**Carrier's Austin Representative**

Box Number 44

**MFDR Date Received**

JUNE 05, 2015

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "We submitted a request for reconsideration to Gallagher Bassett on March 3, 2015. This request was in response to a \$285.90 reduction of the \$866.86 for the EMG/NCV performed on February 4, 2015. Unfortunately our request was not paid according to the Texas Fee Schedule Guidelines and we are seeking the balance owed to us."

**Amount in Dispute:** \$279.48

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Please see the EOBs...Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

**Response Submitted by:** Flahive, Ogden & Latson

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 4, 2015	CPT Code 99204 New Patient Office Visit	\$260.90	\$0.00
	CPT Code 95886 (X2) Needle EMG	\$0.00	\$0.00
	CPT Code 95910 Nerve Conduction Studies (7-8)	\$0.00	\$0.00
	HCPCS Code A4556 Electrodes	\$18.58	\$0.00
TOTAL		\$279.48	\$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:
  - P12-Workers compensation jurisdictional fee schedule adjustment.
  - P300-The amount paid reflects a fee schedule reduction.
  - Z710-The charge for this procedure exceeds the fee schedule allowance.
  - 18-Duplicate claim/service.
  - U301-This item was previously submitted and reviewed with a notification of decision issued to payor, provider (duplicate invoice).
  - W3-Request for reconsideration.
  - 150-Payer deems the information submitted does not support this level of service.
  - 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

### **Issues**

1. Does the documentation support billing CPT code 99204?
2. 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. According to the submitted explanation of benefits, the respondent denied payment for CPT code 99204 based upon reason code "150."

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 Division finds that the requestor's documentation did not support a comprehensive history or medical decision making of moderate complexity. In addition, a separate evaluation and management report was not submitted; therefore, the respondent's denial is supported. As a result, reimbursement is not recommended.

2. According to the explanation of benefits, the respondent paid \$6.42 for HCPCS code A4556.

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**

_____	_____	07/24/2015
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.**