



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

CESAR P. DUCLAIR, MD

Respondent Name

LM INSURANCE CORP

MFDR Tracking Number

M4-16-2362-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

APRIL 11, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: \$282.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill and documentation attached to the medical dispute have been re-reviewed our review is as follows: CPT code 99204...was denied with level of service not supported by documentation, the third key component-Medical Decision making is not supported in the documented report. EMG/NCS diagnostic interpretation is not considered Medical Decision Making-interpretation of the EMB/NCS is the professional component of those codes and should not be counted as required key component of the E&M...HCPCS A4556 was denied as bundled or non-covered procedure based on Medicare guidelines."

Response Submitted By: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 5, 2015	CPT Code 99204 New Patient Office Visit	\$255.66	\$0.00
	CPT Code 95886 (X2) Needle EMG	\$0.00	\$0.00
	CPT Code 95911 Nerve Conduction Studies (9-10)	\$0.00	\$0.00
	HCPCS Code A4556 Electrodes	\$25.00	\$0.00
TOTAL		\$282.66	\$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:
 - X212-This procedure is included in another procedure performed on this date.
 - 97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
 - 150- Payment adjusted because the payer deems the information submitted does not support this level of service.
 - X901-Documentation does not support level of service billed.
 - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - W3-Additional payment made on appeal/reconsideration.

Issues

1. Is the benefit for CPT code 99204 included in the benefit of another service billed on the disputed date? Is the requestor entitled to reimbursement for 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 explanation of benefits, the respondent denied reimbursement for code 99204 based upon reason codes "X212-This procedure is included in another procedure performed on this date," and "97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

28 Texas Administrative Code §133.307 (b)(1) states, "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..."

On the disputed date of service, the requestor billed codes 99204, 95886, 95911 and A4556. Per CCI edits, code 99204 is not bundled to any other service billed on the disputed date; therefore, the respondent's denial based upon reason codes "X212" and "97" is not supported.

CPT code 99204 is defined 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.."

To determine if the requestor is due reimbursement the Division reviewed the submitted documentation and finds that per 28 Texas Administrative Code §134.203(a)(5) "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 Division finds that the requestor did not submit an office visit

report that supports the three key components for billing code 99204. As a result, reimbursement is not recommended.

2. According to the explanation of benefits, the respondent paid \$0.00 for HCPCS code A4556 based upon reason code "B291."

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, 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

_____	_____	5/5/2016
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.