



**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**

JAMES WEISS, MD

**Respondent Name**

LM INSURANCE CORP

**MFDR Tracking Number**

M4-16-2365-01

**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:** \$481.94

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The bill and documentation attached to the medical dispute have been re-reviewed and our position remains unchanged."

**Response Submitted By:** Liberty Mutual Insurance

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 4, 2016	CPT Code 99203 New Patient Office Visit	\$185.78	\$0.00
	CPT Code 95886 (X2) Needle EMG	\$271.16	\$0.00
	CPT Code 95910 Nerve Conduction Studies (7-8)	\$0.00	\$0.00
	HCPCS Code A4556 Electrodes	\$25.00	\$0.00
TOTAL		\$481.94	\$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.
  - X263-The code billed does not meet the level/description of the procedure performed/documentation. Consideration will be given with coding that reflects the documented procedure.
  - 150- Payment adjusted because the payer deems the information submitted does not support this level of service.
  - B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.
  - 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 99203 included in the benefit of another service billed on the disputed date? Is the requestor entitled to reimbursement for CPT code 99203?
2. Does the documentation support billing CPT code 95886? Is the requestor entitled to reimbursement for CPT code 95886?
3. 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 99203 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 99203, 95886, 95910 and A4556. Per CCI edits, code 99203 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 99203 is defined as "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low 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 severity. Typically, 30 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 99203. As a result, reimbursement is not recommended.

2. According to the explanation of benefits, the respondent denied reimbursement for 95886 based upon reason codes "X263-The code billed does not meet the level/description of the procedure performed/documentation. Consideration will be given with coding that reflects the documented procedure," and "150- Payment adjusted because the payer deems the information submitted does not support this level of service."

CPT code 95886 is defined as "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)."

The Division reviewed the submitted documentation and finds that the report does not support five or more muscle studied to support billing code 95886. As a result, reimbursement is not recommended.

3. According to the explanation of benefits, the respondent paid \$0.00 for HCPCS code A4556 based upon reason codes "97," and "X212."

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.**