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
James Weiss, M.D.

Respondent Name
Valley Forge Insurance Company

MFDR Tracking Number
M4-16-3117-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
June 13, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The service provided for EMG/NCV includes an office consultation for this date of service. These CPT Codes are not to be bundled per the fee guidelines. Per the attached report an office consult was performed as part of making an accurate diagnosis for this examinee with regards to the performance of the testing and used in making a final determination. The examination is correlated with clinical findings performed as part of the office consultation. It is documented and billed appropriately."

Amount in Dispute: $311.73

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "**CPT 99204 09/02/2015 -** … CPT code 99204 has been reviewed by Coventry Clinical Validation Team by a Registered Nurse Reviewer. In this case the provider's documented treatment notes do not support the level of service billed CPT code 99204, therefore CPT code 99204 was denied…

CPT 95910 09/02/2015 – Provider billed $333.91 the provider was paid $294.88… No further payment is due as 95910 has been paid as per the TX state fee schedule.

95910 [(2.00 * 1.000) + (3.44 * .920) + (.10 * .822)] * 56.20 = $294.88

CPT A4556 07/17/2014 (sic) **–** Provider billed $25.00 the provider was paid Zero. Per CMS the supplies used for performance of nerve conduction studies are included in the allowance for the nerve conduction studies…"

Response Submitted by: Law Office of Brian J. Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 2, 2015	Evaluation & Management, new patient (99204) Nerve Conduction Study Electrodes	$311.73	$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 §134.203 sets out the fee guidelines for professional services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   For procedure code 99204:
   - "CV: THE LEVEL OF E & M CODE SUBMITTED IS NOT SUPPORTED BY DOCUMENTATION. (V122)"
   - 150 – Payer deems the information submitted does not support this level of service.
   For procedure code 95910:
   - "The amount paid reflects a fee schedule reduction. (P300)"
   - "The charge for this procedure exceeds the fee schedule allowance. (Z710)"
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   For procedure code A4556:
   - "CV: PER CPT GUIDELINES, SUPPLIES OR MATERIALS NORMALLY REQUIRED TO COMPLETE THE PROCEDURE OR SERVICE SHOULD NOT BE BILLED SEPARATELY. (V163)"
   - "The amount paid reflects a fee schedule reduction. (P300)"
   - "The charge for this procedure exceeds the fee schedule allowance. (Z710)"
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - "Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. (ZD86)"
   Additional Notes:
   - "AFTER REVIEW OF THE BILL AND THE MEDICAL RECORD, THIS SERVICE IS BEST DESCRIBED BY 99203. SUBMITTED DOCUMENTATION DID NOT MEET THE 3 KEY COMPONENTS REQUIRED FOR 99204. LACKING A COMPREHENSIVE HISTORY AND A COMPREHENSIVE PHYSICAL EXAMINATION. (ZV31)"
   - "CV RECONSIDERATION – NO ADDITIONAL ALLOWANCE RECOMMENDED. THIS BILL AND SUBMITTED DOCUMENTATION HAVE BEEN RE-EVALUATED BY CLINICAL VALIDATION. SUBMITTED DOCUMENTATION DOES NOT SUPPORT AN ADDITIONAL ALLOWANCE. (Z257)"

Issues

1. What are the services in dispute?
2. What are the rules that determine reimbursement for the disputed services?
3. Are the insurance carrier's reasons for denial of payment for procedure code 99204 supported?
4. What is the maximum allowable reimbursement for procedure code 95910?
5. Are the insurance carrier's reasons for denial of payment for procedure code A4556 supported?
6. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for procedure codes 99204, 95910, and A4556. While the requestor also listed procedure code 95886 on the Medical Fee Dispute Resolution Request (DWC060), he is seeking $0.00 for this service. Therefore, this code will not be considered in this dispute.

2. The disputed services are professional medical services subject to the fee guidelines found in 28 Texas Administrative Code §134.203, which states, in relevant part:

   (b) 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; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity

areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

3. The insurance carrier denied disputed procedure code 99204 with claim adjustment reason code 150 – "Payer deems the information submitted does not support this level of service," and stating, "THE LEVEL OF E & M CODE SUBMITTED IS NOT SUPPORTED BY DOCUMENTATION." The American Medical Association (AMA) CPT code description for 99204 is:

   > 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** [emphasis added]. 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 1997 Documentation Guidelines for Evaluation & Management Services, published by the Centers for Medicare and Medicaid Services (CMS) found at https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/97docguidelines.pdf puts forth the requirements to meet the AMA CPT code description presented. The division will review the submitted documentation to determine if the requirements, as outlined by the 1997 Documentation Guidelines, were met.

   Documentation of a Comprehensive History:

	Requirement	Guideline Elements	Documented Elements	Requirement Met?
Chief Complaint	Statement describing the symptom, etc.	1 statement	"The examinee presents today with complaints to the following areas: Left knee."	Yes
Extended HPI	At least four elements of the HPI.	Location	x	Yes
		Quality	x	
		Severity	x	
		Duration	x	
		Timing	x	
		Context	x	
		Modifying Factors	x	
		Assoc. Signs/Symptoms		
Complete ROS	At least ten organ systems.	Constitutional		No
		Eyes		
		ENT		
		Cardio./Vasc.		
		Respiratory		
		GI		
		GU		
		Musculoskeletal	x	
		Integumentary		
		Neurological	x	
		Psychological		
		Endocrin		
		Hem./Lymph.		
		Allergy/Immun.		
		All Others Neg.		
Complete PFSH	At least one specific item from each of the three history areas.	Past	x	No
		Family		
		Social	x	

The Guidelines state, "To qualify for a given type of history all three elements in the table must be met."

Submitted documentation supports the presence of a chief complaint and an extended history. Because the provider documented only two systems, a complete review of systems was not supported. The provider documented only two areas of history, therefore, a complete PFSH was not supported for a new patient office visit.

The division finds that the submitted documentation does not support a Comprehensive Medical History, which is required for procedure code 99204.

Documentation of a Comprehensive Examination:

The 1997 Documentation Guidelines requires a comprehensive examination to include "a general multi-system examination, or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s)." Review of the submitted report finds that the documented examination most closely supports a single organ system examination for the musculoskeletal system. A "*comprehensive* examination [for a single organ system] …should include performance of all elements [of the Musculoskeletal Examination table]."

System/Body Area	Guideline Elements of Examination	Documented Elements
Cardiovascular	Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)	
Lymphatic	Palpation of lymph nodes in neck, axillae, groin, and/or other location	
Skin	Inspection and/or palpation of skin and subcutaneous tissue (e.g., scars, rashes, lesions, café-au-lait spots, ulcers) in four of the following six areas: 1) head and neck, 2) trunk, 3) right upper extremity, 4) left upper extremity, 5) right lower extremity, 6) left lower extremity. Note: **For the comprehensive level, the examination of all four anatomic areas must be performed and documented**...	
Neurological/ Psychiatric	Test coordination (e.g., finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities, ...)	
	Examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes (e.g., Babinski)	x
	Examination of sensation (e.g., by touch, pin, vibration, proprioception)	x
	Orientation to time, place and person	
	Mood and affect (e.g., depression, anxiety, agitation)	x
Constitutional	Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancilliary staff)	x
	General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)	x
Musculoskeletal	Examination of gait and station	x
	Examination of joint(s), bone(s), and muscle(s)/tendon(s) of four of the following six areas: 1) head and neck; 2) spine, ribs, and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity… Note: **For the comprehensive level of examination, <u>all four elements</u> identified by a bullet must be performed and documented for <u>each of four anatomic areas</u>**...	
	Inspection, percussion and/or palpation with notation of any misalignment, asymetry, crepitation, defects, tenderness, masses or effusions	
	Assessment of range of motion with notation of any pain (e.g., straight leg raising), crepitation or contracture	
	Assessment of stability with notation of any dislocation (luxation), subluxation or laxity	

	Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements	

A review of the submitted report finds that nine of the required elements were not sufficiently documented. Therefore, submitted documentation does not support a Comprehensive Examination, which is required for procedure code 99204.

- Documentation of Decision Making of Moderate Complexity:

  The 1997 Documentation Guidelines states:

  Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option, as measured by:
  - The number of possible diagnoses and/or the number of management options that must be considered
  - The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
  - The risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

  The submitted report is considered for the presence of the following elements:

  - *Number of diagnoses or treatment options*

Problem(s) Status	Number	Documented
Self-limited or minor (stable, improved or worsening)	Max 2	
Est. problem (to examiner); stable, improved		
Est. problem (to examiner); worsening		
New problem (to examiner); no additional workup planned	Max 1	x
New problem (to examiner); additional workup planned		

  Review of the submitted documentation finds that a new problem to the examiner was presented with no additional workup planned, meeting the documentation requirements of moderate complexity. The performance of the electromyography and nerve conduction study was not considered, as the decision to perform this testing was the purpose of the referral and not a result of the examination. Documentation supports that this element was met.

  - *Amount and/or complexity of data to be reviewed*

Reviewed Data	Documented
Review and/or order of clinical lab tests	
Review and/or order of tests in the radiology section of CPT	
Review and/or order of tests in the medicine section of CPT	
Discussion of test results with the performing physician	
Decision to obtain old records and/or obtain history from someone other than patient	
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider	x
Independent visualization of image, tracing or specimen itself (not simply review of report)	

Review of the documentation finds that the requestor reviewed and summarized the relevant findings from other providers. Moderate complexity in decision-making requires moderate complexity of data. The documentation supports that this element met the criteria for limited complexity of data reviewed.

- *Risk of complications and/or morbidity or mortality*

  Review of the submitted documentation finds that presenting problems include one chronic injury, which presents a moderate level of risk, per the Table of Risk found in the 1997 Documentation Guidelines. "The highest level of risk in any one category…determines the overall risk." The documentation supports that this element met the criteria for moderate risk.

The 1997 Documentation Guidelines requires that "To qualify for a given type of decision making, **two of the three elements … must be either met or exceeded**." A review of the submitted documentation supports that this component of procedure Code 99204 was met.

Because only one component of procedure Code 99204 met the documentation requirements, the requestor failed to support the level of service required by 28 Texas Administrative Code §134.203. The insurance carrier's denial for this procedure code is supported. Additional reimbursement cannot be recommended.

4. The insurance carrier reduced procedure code 95910 with procedure code P12 – "Workers' compensation jurisdictional fee schedule adjustment," stating, "The amount paid reflects a fee schedule reduction," and "The charge for this procedure exceeds the fee schedule allowance." 28 Texas Administrative Code §134.203(c) 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…
   (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 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. The Division conversion factor for 2015 is $56.20.

   For procedure code 95910 on September 2, 2015, the relative value (RVU) for work of 2.00 multiplied by the geographic practice cost index (GPCI) for work of 1.000 is 2.000000. The practice expense (PE) RVU of 3.44 multiplied by the PE GPCI of 0.920 is 3.164800. The malpractice (MP) RVU of 0.10 multiplied by the MP GPCI of 0.822 is 0.082200. The sum of 5.247000 is multiplied by the Division conversion factor of $56.20 for a MAR of $294.88.

5. The insurance carrier denied disputed procedure code A4556 with claim adjustment reason codes 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated," and P12 – "Workers' compensation jurisdictional fee schedule adjustment," stating, "PER CPT GUIDELINES, SUPPLIES OR MATERIALS NORMALLY REQUIRED TO COMPLETE THE PROCEDURE OR SERVICE SHOULD NOT BE BILLED SEPARATELY," "The amount paid reflects a fee schedule reduction," and "The charge for this procedure exceeds the fee schedule allowance."

   Procedure code A4556 is defined as "Electrodes (e.g., apnea monitor), per pair." Medicare gives this procedure code a status of "P," which is defined as "Bundled/Excluded Codes," and states, in relevant part, "No separate payment should be made for them under the fee schedule. – If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident." Therefore, the insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

6. The total allowable for the disputed services is $294.88. The insurance carrier paid $297.88. No further reimbursement is 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 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	November 18, 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.