



# 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**

Federal Insurance Co

**MFDR Tracking Number**

M4-16-3119-01

**Carrier's Austin Representative**

Box Number 17

**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:** \$285.90

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The documentation provided for this date of service does not show Requestor performed all three components as required. The report shows a comprehensive history and a comprehensive examination were completed. There was no medical decision making of moderate complexity. In fact, there was not medial decisions discussed at all. Because Requestor did not complete all three requirements, reimbursement is not owed for the service. The electrodes used during EMG/NCV were billed using CPT code A4556. However, separate payment is not owed for these supplies as they are considered inclusive to the services performed. In conclusion, no monies should be awarded to Requestor for CPT codes 99204 and A4556."

**Response Submitted by:** Downs ♦ Stanford

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 11, 2015	99204, A4556	\$285.90	\$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 reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 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
  - W3 – Request for reconsideration

**Issues**

1. The insurance carrier denied disputed service 99204 with claim adjustment reason code 150 – “Payer deems the information submitted does not support this level of service.” 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; 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.

The submitted code in dispute has a narrative description of 99204 – Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 components: A comprehensive history: A comprehensive examination: Medical decision making of moderate complexity.

Review of the submitted document titled, “Electromyography (EMG) Report finds the following:

Required Element	Present within Submitted Documentation Findings	Requirement of Code Met
Comprehensive History	History of Present illness – 1 condition Review of systems – Musculoskeletal Past Medical History	No – Report supports Expanded Problem Focused
Comprehensive Examination	Body Areas – Neck, Right Shoulder	No – Report supports Expanded Problem Focused
Moderate complexity medical decision making	Number of Diagnoses or Treatment options – 1 Amount and/or Complexity of Data Reviewed – 1 (Discussion of test results) Risk of Significant Complications, Morbidity, and/or Mortality - Low	No – Reports supports Straightforward

Based on the above, the carrier’s denial is supported.

The carrier denied code A4556 as 97 – “The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.” Review of Code A4556 status finds “P” or excluded as incident to a physician’s service (not separately payable).” As this service is incident to the Needle EMG/Nerve Conduction Study, the carrier’s denial is supported.

2. Pursuant to provisions of Rule 134.203 (b), no additional 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**

Signature	Medical Fee Dispute Resolution Officer	July , 2016 Date
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***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.**