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
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-20-1443-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
OCTOBER 23, 2019

REQUESTOR'S POSITION SUMMARY

"The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134…**DESIGNATED DOCTOR REFERRED TESTING…NO PRE-AUTHORIZATION IS REQUIRED**."

Amount in Dispute: $352.66

RESPONDENT'S POSITION SUMMARY

"This is not a network claim as this is for DDE ordered testing…The bill for 7/18/19 and has been adjusted and payment issued for 95886. HCPCS Codes A4556…and A4215…were denied as supplies are not separately payable per Medicare guidelines."

Response Submitted By: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 18, 2019	CPT Code 99204-25 New Patient Office Visit	$0.00	$0.00
	CPT Code 95886 Needle EMG	$321.05	$0.00
	CPT Code 95912 Nerve Conduction Studies	$0.00	$0.00
	HCPCS Code A4556 Electrodes	$16.90	$0.00
	HCPCS Code A4215 Needles	$14.71	$0.00
TOTAL		$352.66	$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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
2. 28 TAC §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 code:
   - 197, 5876-According to the Texas Division of Workers Compensation's rules effective May 1, 2007, all medical treatment provided to workers Compensation patients in the state of Texas must follow the Official Disability Guidelines (ODG). The services provided are outside the ODG guidelines and no pre authorization was requested.
   - P12-Workers' compensation fee schedule adjustment.
   - 309-The charge for this procedure exceeds the fee schedule allowance.
   - 97, 243-The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
   - W3-Additional payment made on appeal/reconsideration.
   - 193-The original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to additional reimbursement for services rendered on July 18, 2019?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $352.66 for CPT codes 95886, A4556 and A4215 rendered on July 18, 2019.
2. The respondent initially denied reimbursement for CPT code 95886 based upon a lack of preauthorization. The respondent wrote, "The bill for 7/18/19 and has been adjusted and payment issued for 95886." In support of their position, the respondent submitted a copy of EOB and check that supports payment issued in the disputed amount of $321.05; therefore, the DWC considers the issue for CPT code 95886 resolved.
3. The fee guidelines for disputed services are found in 28 TAC §134.203.
4. 28 TAC §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."
5. The requestor is seeking medical dispute resolution for $16.90 for HCPCS code A4556.

   HCPCS code A4556 is defined as "Electrodes (e.g., apnea monitor), per pair."

   The respondent denied reimbursement based upon unbundling.

   Per Medicare physicians' fee schedule, code A4556, is a status "P" code.

   Status "P" codes are defined as "Bundled/excluded codes. There are no RVUs and no payment amounts for these services. No separate payment is 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 (an example is an elastic bandage furnished by a physician incident to a physician service). If the item or service is covered as other

than incident to a physician service, it is excluded from the fee schedule (for example, colostomy supplies) and is paid under the other payment provision of the Act."

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.

6. The requestor is seeking medical dispute resolution for $14.71 for HCPCS code A4215.

   HCPCS code A4215 is defined as "Needle, sterile, any size, each."

   The respondent denied reimbursement based upon the fee guideline.

   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 A4215 in conjunction with CPT codes 95886 and 95911. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement is due.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		03/05/2020
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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **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.