



# 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**

NEW HAMPSHIRE INSURANCE COMPANY

**MFDR Tracking Number**

M4-20-2299-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

May 18, 2020

**Response Submitted by:**

Gallagher Bassett

### **REQUESTOR'S POSITION SUMMARY**

"Service codes and CPT codes are not to be bundled nor compounded and are to be billed and reimbursed separately and independently from one another. You will note in the attached narrative report and testing results all required and billed components were performed and documented appropriately utilizing the above TDI-DWC Fee Guidelines and should not be reduced... Additionally, as you can see from the attached report an examination was performed and documented as a Detailed Examination component and billed as 99202 [sic]. See report for all 6[sic] elements required for a general multi-system examination."

### **RESPONDENT'S POSITION SUMMARY**

"Attached is a copy of all bills received to date, and their corresponding EOB's and payment details."

### **SUMMARY OF FINDINGS**

| Dates of Service  | Disputed Services                               | Amount in Dispute | Amount Due    |
|-------------------|---|-------------------|---------------|
| February 25, 2020 | Evaluation & Management (99203-25)              | \$185.99          | \$0.00        |
| February 25, 2020 | Needle Electromyography, each extremity (95886) | \$0.00            | \$0.00        |
| February 25, 2020 | Nerve Conduction Studies, 9-10 studies (95911)  | \$0.00            | \$0.00        |
| February 25, 2020 | Electrodes, per pair (A4556)                    | \$16.90           | \$0.00        |
| February 25, 2020 | Needle, sterile, any size, each (A4215)         | \$14.14           | \$0.00        |
| <b>TOTAL</b>      |   | <b>\$217.03</b>   | <b>\$0.00</b> |

## ***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 medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 00576 – (234) This procedure is not paid separately
  - 00223 – (P12) Workers compensation jurisdictional fee schedule adjustment
  - Z710 – The charge for this procedure exceeds the fee schedule allowance
  - 00216 – (P5) Based on payer reasonable and customary fees, no maximum allowable defined by legislated fee arrangement
  - Z711 –The charge for this procedure exceeds the customary charges by other providers for this service
  - 00214 – (W3) Additional payment made on appeal/reconsideration

### **Issues**

1. What are the services in dispute?
2. Did the insurance carrier issue payment for CPT Code 99203-25?
3. What are the applicable rules for the disputed services?
4. Did the insurance carrier issue payment for disputed HCPCs code A4215?
5. Is the insurance carrier's denial reason for HCPCs code A4556 supported?

### **Findings**

1. The requestor billed for CPT /HCPC codes 99203-25, 95886, 95911, A4556, and A4215 on February 25, 2020. The DWCO60 Table of Dispute Services identifies that the requestor not seeking reimbursement for CPT Codes 95886 and 95911, as the insurance carrier reimbursed the requestor for these services. Therefore, these services will not be considered in this dispute. The requestor seeks reimbursement in the amount of \$217.03 for procedure codes 99203-25, A4556, and A4215. These services are reviewed pursuant to applicable rules and guidelines.
2. Review of the Explanation of Benefit (EOB) dated May 12, 2020 supports that a payment was issued to the requestor for CPT Code 99203-25 in the amount of \$185.99. The requestor sought \$185.99; therefore, no additional reimbursement is recommended.
3. Reimbursement for the disputed codes are subject to the fee guidelines for professional medical services found in 28 TAC §134.203(b)(1), which 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; ... and other payment policies in effect on the date a service is provided...
4. The requestor seeks reimbursement for HCPCs code A4215 rendered on February 25, 2020. The insurance carrier denied the disputed service with claim adjustment reason codes 00223, P12, W3 and Z710 (description provided above).

Medicare payment policy finds that HCPCs code A4215 has a status of Statutory Exclusion, which means,

These codes represent an item or service that is not in the statutory definition of "physician services" for fee schedule payment purposes. No RVUS or payment amounts are shown for these codes, and no payment may be made under the physician fee schedule...

The DWC finds that reimbursement for this service cannot be recommended. As a result, \$0.00 is recommended.

5. The insurance carrier denied HCPCs code A4556 with claim adjustment reason codes 00576, 234 and W3.

The division finds that HCPCs code A4556 is a Bundled/Excluded code, which means:

There are no RVUs and no payment amounts for these services. 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. (An example is an elastic bandage furnished by a physician incident to physician service.)--If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (i.e., colostomy supplies) and should be paid under the other payment provision of the Act.

The Medicare Benefit Policy Manual, Chapter 15 §60.1 states, "Incident to a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness." The services are incident to the physician services furnished the same day; and are considered bundled into those services. The DWC finds that the insurance carrier's denial is supported and therefore, reimbursement for this service cannot be 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

\_\_\_\_\_  
June 10, 2020  
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 TAC §133.307, effective May 31, 2012, 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 MDR 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 TAC §141.1(d).

Si prefieres hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812