



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
BAHZAD AALAEI, MD

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-12-0024-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
SEPTEMBER 1, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We would like the insurance carrier to negotiate additional payment or pay the difference on the services in dispute."

Amount in Dispute: \$127,979.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the requestor has in no way demonstrated how it is due any additional payment."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Rows include various medical services like Office Visits, Drug Screen Tests, and Lumbar Myelograms with associated dates and amounts.

February 16, 2011 March 2, 2011	CPT Code A4550 Surgical Trays	\$9,600.00/ea	\$0.00
February 16, 2011 March 2, 2011	CPT Code 93005 EKG	\$380.00/ea	\$0.00
February 16, 2011 March 2, 2011	CPT Code 94761 Noninvasive Ear or Pulse Oximetry	\$380.00/ea	\$0.00
February 16, 2011 March 2, 2011	CPT Code S0020 Bupivacaine HCL, Injection, 30ml	\$6,000.00/ea	\$0.00
February 16, 2011 March 2, 2011	CPT Code J2250 Midazolam HCL, Injection, per 1mg	\$7,999.91/ea	\$0.00
February 16, 2011 March 2, 2011	CPT Code 99144 Moderate Sedation Services	\$4,445.86/ea	\$0.00
March 2, 2011	CPT Code 64483 Lumbar Injection	\$3,429.77	\$0.00
March 2, 2011	CPT Code 64484 Lumbar Injection	\$3,635.83	\$0.00
March 2, 2011	CPT Code 72275 Epidurography	\$9,800.00	\$0.00
March 2, 2011	CPT Code J1030 (X4) Methylprednisolone Acetate Injection, 40 mg	\$11,986.04	\$3.04
April 7, 2011	CPT Code 80101 Drug Screen	\$180.00	\$0.00
TOTAL		\$127,979.25	\$3.04

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, effective May 25, 2008, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
3. 28 Texas Administrative Code §134.1, effective March 1, 2008, sets forth general provisions related to medical reimbursement.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC-W1-Workers compensation state fee schedule adjustment.
 - CAC-4-The procedure code is inconsistent with the modifier used or a required modifier is missing.
 - CAC-150-Payer deems the information submitted does not support his level of service.
 - CAC-16-Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code).
 - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.

- 732-Accurate coding is essential for reimbursement. CPT and/or modifier billed incorrectly. Services are not reimbursable as billed.
- 758-ODG documentation requirements for urine drug testing have not been met.
- 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
- 890-Denied per AMA CPT code description for level of service and/or nature of presenting problems.
- 891-No additional payment after reconsideration.
- CAC-97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 217-The value of this procedure is included in the value of another procedure performed on this date.
- 284-No allowance was recommended as this procedure has a Medicare status of "B" (Bundled)
- 435-Per NCCI Edits, the value of this procedure is included in the value of the comprehensive procedure.
- 612-No payment is made as Medicare uses another code for reporting and/or payment of this service.
- 714-Accurate coding is essential for reimbursement, CPT billed incorrectly services are not reimbursable as billed.
- 876-Required documentation missing or illegible, see rules 133.1, 133.210, 129.5, or 180.22.
- CAC-18-Duplicate claim/service.
- 224-Duplicate charge.
- 629-The medically unlikely edits (MUE) from CMS has been applied to this procedure code.
- 754-Not a request for reconsideration; does not include same billing codes DOS and/or dollar amounts as original bill per rule 133.250.
- CAC-226-Information requested from the billing/rendering provider was not provided or was insufficient/incomplete.
- CACB18-This procedure code and modifier were invalid on the date of service.
- 893-This code is invalid or not covered or has been deleted.

Issues

1. Does medical fee dispute resolution have jurisdiction to review this dispute?
2. Is the requestor entitled to additional reimbursement for code 99204?
3. Does the documentation support billing code G0431-QW on January 10, February 10, March 2, and March 9, 2011? Is the requestor entitled to reimbursement?
4. Is the requestor entitled to additional reimbursement for code 99213 rendered on February 10, March 9, and April 7, 2011?
5. Is the requestor entitled to additional reimbursement for code 62284?
6. Is the requestor entitled to additional reimbursement for code 72265?
7. Is the requestor entitled to additional reimbursement for code Q9966?
8. Is the allowance of code A4550 included in the allowance of another service rendered on the disputed date of service? Is the requestor entitled to reimbursement?
9. Is the requestor entitled to additional reimbursement for code 93005?
10. Is the allowance of code 94761 included in the allowance of another service rendered on the disputed date of service? Is the requestor entitled to reimbursement?
11. Is the requestor entitled to reimbursement for code S0020?
12. Is the requestor entitled to additional reimbursement for code J2250?
13. Is the requestor entitled to additional reimbursement for code 99144?
14. Is the requestor entitled to additional reimbursement for code 64483?
15. Is the requestor entitled to additional reimbursement for code 64484?
16. Is the allowance of code 72275 included in the allowance of another service rendered on the disputed date of service? Is the requestor entitled to reimbursement?
17. Is the requestor entitled to additional reimbursement for code J1030?

18. Does the documentation support billing code 80101? Is the requestor entitled to reimbursement?

Findings

1. The requestor provided professional services in the state of Indiana from January 10, 2011 through April 7, 2011 to an injured employee with an existing Texas Workers' Compensation claim. The requestor was dissatisfied with the respondent's final action. The requestor filed for reconsideration and was denied payment after reconsideration. The requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The Division concludes that because the requestor sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.
2. According to the submitted explanation of benefits, the respondent paid \$244.49 for an office visit, code 99204, based upon the fee guideline.

28 Texas Administrative Code §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."

Per 28 Texas Administrative Code §134.203(c)(1)(2), "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. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(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 following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: $(\text{DWC Conversion Factor} / \text{Medicare Conversion Factor}) \times \text{Participating Amount} = \text{Maximum Allowable Reimbursement (MAR)}$.

The 2011 DWC conversion factor for this service is 54.54.

The Medicare Conversion Factor is 33.9764

The Medicare participating amount is based on locality "Indiana".

The Medicare participating amount \$152.61.

Using the above formula, the Division finds the MAR is \$244.49. The respondent paid \$244.49. The difference between the MAR and amount paid is \$0.00. As a result, additional reimbursement is not recommended.

3. Based upon the submitted documentation, the respondent denied reimbursement for code G0431-QW rendered on January 10, February 10, March 2, and March 9, 2011 based upon a lack of documentation.

28 Texas Administrative Code §133.307(c)(2)(E) requires the requestor to submit "a copy of all applicable medical records specific to the dates of service in dispute" to Medical Fee Dispute Resolution. A review of the requestor's dispute packet finds no medical records to support code G0431-QW ; therefore, the respondent's denial reason is supported. As a result, reimbursement is not recommended.

4. According to the explanation of benefits, the respondent paid for the office visits, CPT code 99213, rendered on February 10, March 9, and April 7, 2011 based upon the fee schedule. Using the above formula, the Division finds the MAR is \$106.88/ea. The respondent paid \$106.88/ea. The difference between the MAR and amount paid is \$0.00. As a result, additional reimbursement is not recommended.
5. On February 16, 2011, the requestor billed and was paid \$328.45 for CPT code 62284. Using the above formula, the Division finds the MAR is \$328.45. The difference between the MAR and amount paid is \$0.00. As a result, additional reimbursement is not recommended.
6. On February 16, 2011, the requestor billed and was paid \$213.93 for CPT code 72265. Using the above formula, the Division finds the MAR is \$213.93. The difference between the MAR and amount paid is \$0.00. As a result, additional reimbursement is not recommended.
7. Based upon the submitted explanation of benefits, the respondent paid \$0.40 for code Q9966 based upon the fee schedule. A review of the Medicare fee schedule finds that code Q9966 is not priced.

Per 28 Texas Administrative Code §134.203 “(f) For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).”

28 Texas Administrative Code §134.1, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers’ compensation health care network shall be made in accordance with subsection 134.1(f), which states that “Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.”

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(G), requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.”

- The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
- The requestor did not submit documentation to support that additional reimbursement of \$5,999.60 was due.
- The requestor does not discuss or explain how additional reimbursement of \$5,999.60 is a fair and reasonable reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended

8. According to the explanation of benefits, the respondent denied reimbursement for the surgical trays, code A4550, rendered on February 16 and March 2, 2011 based upon reason codes "97" and "284." The requestor billed for the surgical trays on February 16, 2011 in conjunction with a lumbar myelogram; and on March 2, 2011 with lumbar injections.

28 Texas Administrative Code §134.203(b)(1) "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: 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."

Per Medicare guidelines, code A4550 is a status "B-Bundled" code; therefore, separate reimbursement is not recommended.

9. The respondent stated in the position summary that "Code 93005-59 was denied incorrectly. Texas Mutual will pay the fee schedule for this code." Using the above formula, the Division finds the MAR is \$16.50. The respondent paid \$16.50. The difference between the MAR and amount paid is \$0.00. As a result, additional reimbursement is not recommended.
10. According to the explanation of benefits, the respondent denied reimbursement for code 94761, rendered on February 16 and March 2, 2011 based upon reason codes "97" and "435." The requestor billed for the code 94761 on February 16, 2011 in conjunction with a lumbar myelogram; and on March 2, 2011 with lumbar injections.

Per Medicare guidelines, code 94761 is a status "T-Injection" code. Status "T" is defined as "There are RVUS and payment amounts for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made. (NOTE: This is a change from the previous definition, which states that injection services are bundled into any other services billed on the same date.)" As stated above, code 94761 was billed with other payable services on the disputed dates; therefore, separate reimbursement is not recommended.

11. According to the explanation of benefits, the respondent denied reimbursement for code S0020, rendered on February 16 and March 2, 2011 based upon reason codes "4" and "732."

Per Medicare guidelines, code S0020 is not a covered code as of January 1, 2007; therefore, reimbursement is not recommended.

12. The respondent states in the position summary that "Medicare's ASP pricing in 2011 for code J2250 is \$0.144 per 1mg. Texas Mutual initially paid \$.09, an underpayment of \$0.09." The respondent paid the additional \$.09. The Division finds that the requestor did not submit any documentation to support billing or additional reimbursement for code J2250. As a result, additional reimbursement is not recommended.

28 Texas Administrative Code §134.203(d)(1 and 2) states, "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

- (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; or
- (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS."

A review of DMEPOS finds that code J2250 does not have a fee schedule. Therefore, in accordance with 28 Texas Administrative Code §134.203(d)(2), the Division finds that Texas Medicaid sets a fee schedule of \$0.09 for code J2250; therefore, $\$.09 \times 125\% = \$.11$. Based upon the previous payment of \$.18, additional reimbursement is not recommended.

13. According to the explanation of benefits, the respondent paid \$54.14 for code 99144 based upon the fee guideline. Per Medicare fee schedule, code 99144 does not have a relative value; therefore, 28 Texas Administrative Code §134.203(f) applies.

Per 28 Texas Administrative Code §134.203 “(f) For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).”

28 Texas Administrative Code §133.307(c)(2)(G), requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.”

- The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
- The requestor did not submit documentation to support that additional reimbursement of \$4,445.86 was due.
- The requestor does not discuss or explain how additional reimbursement of \$4,445.86 is a fair and reasonable reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

14. According to the explanation of benefits, the respondent paid \$370.23 for code 64483 based upon the fee guideline. Using the above formula, the Division finds the MAR is \$370.23. The difference between the MAR and amount paid is \$0.00. As a result, additional reimbursement is not recommended.
15. According to the explanation of benefits, the respondent paid \$164.17 for code 64484 based upon the fee guideline. Using the above formula, the Division finds the MAR is \$164.17. The difference between the MAR and amount paid is \$0.00. As a result, additional reimbursement is not recommended.
16. According to the explanation of benefits, the respondent denied reimbursement for code 72275, rendered on March 2, 2011 based upon reason codes “97” and “217.” The requestor billed for code 72275 in conjunction with the lumbar injections.

Per CCI edits, code 72275 is a component of code 64483; however, a modifier is allowed to differentiate the service. A review of the requestor’s billing finds that the requestor appended modifier “59” to code 72275.

Modifier 59 is defined as “Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59

is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.”

A review of the submitted documentation finds that the requestor did not submit a report to support billing code 72275. In addition, the requestor did not submit documentation to support “a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury” for using modifier 59. The Division concludes that the respondent’s denial of code 72275 is supported. As a result, reimbursement is not recommended.

17. The respondent states in the position summary that “Medicare’s ASP pricing in 2011 for code J1030 is \$3.29 for 40mg of Methylprednisolone. Texas Mutual correctly paid \$13.96.”

28 Texas Administrative Code §134.203(d)(1 and 2) states, “The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

- (3) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; or
- (4) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS.”

A review of DMEPOS finds that code J1030 does not have a fee schedule. Therefore, in accordance with 28 Texas Administrative Code §134.203(d)(2), the Division finds that Texas Medicaid sets a fee schedule of \$3.40 for code J10.30; therefore, $\$3.40 \times 125\% = \4.25 . The requestor billed for four units, therefore, $\$4.25 \times 4 = \17.00 . The respondent paid \$13.96. As a result, additional reimbursement of \$3.04 is recommended.

18. Based upon the submitted documentation, the respondent denied reimbursement for code 80101 rendered on April 7, 2011 based upon a lack of documentation.

28 Texas Administrative Code §133.307(c)(2)(E) requires the requestor to submit “a copy of all applicable medical records specific to the dates of service in dispute” to Medical Fee Dispute Resolution. A review of the requestor’s dispute packet finds no medical records to support code 80101; therefore, the respondent’s denial reason is supported. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$3.04.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$3.04 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

11/13/2015
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

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