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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
JAMES GARRISON MD

Respondent Name
FREESTONE INSURANCE CO

MFDR Tracking Number
M4-12-0766-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
NOVEMBER 4, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DESIGNATED DOCTOR REFERRED DIAGNOSTIC TESTING."

Amount in Dispute: $1092.08

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 9, 2011	CPT code 99202	$114.73	$0.00
	CPT code 95861 Needle electromyography; 2 extremities with or without related paraspinal areas	$211.93	$211.30
	CPT code 95900 (X4) Nerve Conduction Study-Sensory	$388.28	$387.12
	CPT code 95904 (X2) Nerve Conduction Study - Motor	$171.08	$170.58
	CPT code 95934 (X2) H-reflex Test	$181.06	$180.52
	HCPCS code A4556 Electrodes	$25.00	$0.00
TOTAL		$1092.08	$949.52

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 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective

March 1, 2008, sets the reimbursement guidelines for the disputed service.

3. Neither party to the dispute submitted explanation of benefits to support issue in dispute; therefore, the disputed services will be reviewed per applicable Division rules and guidelines.

Issues

1. Is the requestor entitled to reimbursement for CPT code 99202?
2. Is the requestor entitled to reimbursement for CPT codes 95861, 95900, 95904, and 95934?
3. Is the requestor entitled to reimbursement for HCPCS code A4556?

Findings

1. 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."

   CPT Code 99202 is defined as "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. 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 low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family."

   A review of the submitted medical records finds that the requestor did not submit a separate report for the office visit. The requestor submitted nerve conduction/EMG report. Therefore, the requestor has not supported billing CPT code 99202. As a result, reimbursement is not recommended.

2. 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."

   The 2011 DWC conversion factor is $54.54.

   The 2011 Medicare conversion factor is 33.9764

   Review of Box 32 on the CMS-1500 the services were rendered in Dallas,Texas; therefore, the Medicare participating amount will be based on the rate for Dallas, Texas.

   Using the Above Formula the Division finds the following:

CODE	MEDICARE PARTICIPATING AMOUNT	MAXIMUM ALLOWABLE REIMBURSEMENT	TOTAL AMOUNT PAID	TOTAL AMOUNT DUE
95861	$131.63	$211.30	$0.00	$211.30
95900	$60.29	$96.78 X 4 = $387.12	$0.00	$387.12
95904	$53.13	$85.29 X 2 = $170.58	$0.00	$170.58
95934	$56.23	$90.26 X 2 = $180.52	$0.00	$180.52

3. HCPCS code A4556 is defined as "Electrodes (e.g., apnea monitor), per pair." Per Medicare policy HCPCS code A4556 is a bundled code; therefore, 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 $949.52.

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 $949.52 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		05/08/2014
Signature	Medical Fee Dispute Resolution Officer	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 512-804-4812.