**Texas Department of Insurance**
**Division of Workers' Compensation**
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

Requestor Name and Address:

BARBARA SIGAL, MD
3100 TIMMONS LANE
HOUSTON, TX 77027

MFDR Tracking #: M4-10-5265-01

DWC Cl

Injure

Date o

Employe

Insurance

Respondent Name and Box #:

SERVICE LLOYDS INSURANCE CO
Box #: 42

## PART II: REQUESTOR'S POSITION SUMMARY

**The Requestor did not submit a position summary in accordance with rule §133.307.**

**Amount in Dispute:** $292.84

## PART III: RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Based on the DWC-60, the Requestor is seeking reimbursement for services rendered. The Requestor billed $866.20 for testing on date-of-service June 29, 2010 and Respondent paid $573.36. The Requestor is seeking reimbursement in the amount of $292.84. If this is not the stated dispute, then please contact the undersigned so that the Respondent and the undersigned are aware of any different issue in dispute and may prepare a proper response. Respondent reserves the right to add or supplement this response with additional information, if necessary. As indicated on the explanations of review, the charges for these services were denied on the basis that the maximum number of unites {sic} were exceeded. The claimant sustained only a compensable left wrist injury. All testing performed on the right wrist were denied as excessive treatment. Apparently, the provider performed a bilateral comparison which is not covered under the Fee Schedule. Therefore, full payment for these two services was properly denied. Wherefore, Respondent seeks a finding that Requestor is denied any additional reimbursement for this date of service. Respondent respectfully requests consideration of its position stated herein, and seeks continued denial of any additional reimbursement. If the Division issues any decision ordering additional reimbursement, the Respondent requests a hearing to defend its position."

## PART IV: SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Calculations | Amount in Dispute | Amount Due |
|---|---|---|---|---|
| 6/29/10 | 95900 | N/A | $142.08 | $0.00 |
| 6/29/10 | 95904 | N/A | $125.76 | $0.00 |
| 6/29/10 | A4556 | N/A | $25.00 | $0.00 |
| | | | **Total Due:** | $0.00 |

## PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §134.203 sets out the medical fee guidelines for professional services rendered on or after March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 7/13/2010
   - 505 – Maximum units exceeded, payment adjusted.
   - W1 - Workers' compensation state fee schedule adj.
   - B15 - Procedure/service is not paid separately.
   - RG4 – Service is incidental per Medicare guidelines.

   Explanation of benefits dated 8/3/2010
   - 168 – No additional allowance recommended.
   - 193 – Original payment decision maintained.
   - B15 - Procedure/service is not paid separately.

**Issues**

1. Did the Requestor bill the correct number of units for CPT codes 95900 and 95904?
2. Is HCPCS code A4556 bundled into services billed on the same date of service?
3. Is the requestor entitled to reimbursement?

**Findings**

1. Pursuant to rule 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; and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules. The Requestor billed four units each for CPT codes 95900 (motor nerve conduction study) and 95904 (sensory nerve conduction study). The Requestor was reimbursed by the Respondent for two units each for CPT codes 95900 and 95904. Documentation submitted by the Requestor supports that bilateral studies were performed on the median and ulnar sensory nerves **and** motor nerves. The Medicare guidelines support that both CPT codes 95900 and 95904 have a bilateral surgery indicator status of "0" which means that payment for bilateral procedures does not apply. Therefore, reimbursement for CPT codes 95900 and 95904 is not recommended.
2. The Requestor also billed for HCPCS code A4556 (electrodes). Per the NCCI edits, HCPCS code A4556 is bundled into payment for other services billed on the same date. Therefore reimbursement for HCPCS code A4556 is not recommended.

**Conclusion**

For the reasons stated above, the division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is $0.00.

## PART VI: 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 reimbursement for the disputed services.

| [redacted] | [redacted] | 10/27/10 |
|---|---|---|
| Authorized Signature | Medical Fee Dispute Resolution Officer | Date |

## PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (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. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

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