



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

G. PETER FOOX, MD

Respondent Name

LIBERTY MUTUAL FIRE INSURANCE

MFDR Tracking Number

M4-13-2672-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

JUNE 18, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary.

Amount in Dispute: \$1,300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This dispute has been referred to our Clinical Review Specialists for additional research and review."

Respondent's Supplemental Position Summary: "Nolene also gave permission to correct the billed charges on each code to process these codes to the allowed Texas Workers' Compensation fee schedule amounts for the additional payment due in the amount of \$316.64... The total amount payable for CPT 95910 and 95885 X 2 is \$466.64."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 8, 2013	CPT Code 95910 Nerve Conduction Studies (7-8)	\$1,050.00	\$81.13
	CPT Code 95861 Needle EMG	\$250.00	
TOTAL		\$1,300.00	\$81.13

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203, effective March 1, 2008, 33 *Texas Register* 364, sets the reimbursement guidelines for the disputed service.
- The services in dispute were reduced/denied by the respondent with the following reason codes:

- U899-Procedure has exceeded the maximum allowed units of service.
- X901-Documentation does not support level of service billed.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- X598-Claim has been re-evaluated based on additional documentation submitted; no additional payment due.
- B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.

Issues

1. Does the documentation support billing CPT codes 95910 and 95861?
2. Is the requestor entitled to additional reimbursement for CPT codes 95910 and 95861?

Findings

1. The respondent states” Nolene also gave permission to correct the billed charges on each code to process these codes to the allowed Texas Workers’ Compensation fee schedule amounts for the additional payment due in the amount of \$316.64...The total amount payable for CPT 95910 and 95885 X 2 is \$466.64.”

The Division attempted to verify that services remained in dispute via email communication to the requestor on December 15, 2014. At the time of review, the requestor had not responded to the Division regarding the payment of the disputed services.

On the disputed date of service the requestor billed CPT codes 95910 and 95861.

CPT code 95910 is defined as “Nerve conduction studies; 7-8 studies.” A review of the submitted report supports billed service; therefore, reimbursement per fee guideline is recommended.

CPT code 95861 is defined as “Needle electromyography; 2 extremities with or without related paraspinal areas.” The requestor wrote “Needle EMG of selected muscles of both LEs’; therefore, documentation supports billed service and reimbursement is recommended per fee guideline.

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.”

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2013 DWC conversion factor for this service is 55.3.

The Medicare Conversion Factor is 34.023

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75702, which is located in Tyler, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for “Rest of Texas”.

Using the above formula, the Division finds the following:

Code	Medicare Participating Amount	Maximum Allowable	Carrier Paid	Due
95910	\$173.43	\$281.89	\$466.64	\$81.13
95861	\$163.58	\$265.88		

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due for the specified services. As a result, the amount ordered is \$81.13.

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 \$81.13 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	12/19/2014
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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, 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 Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division 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 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 §141.1(d).

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