



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

Dr. James Weiss MD

Respondent Name

Safety First Insurance Co

MFDR Tracking Number

M4-15-2145-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

March 16, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to Matrix Absence Management on January 5, 2015, this request was in response to a \$430.25 reduction of the \$863.96 for the EMG/NCV Designated Doctor Referred performed on March 20, 2014. Unfortunately our request was denied and we are seeking the balance owed to us."

Amount in Dispute: \$863.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier issued reimbursement based upon fee reductions required by the medical fee guideline and Medicare payment requirements. No additional reimbursement is owed."

Response Submitted by: Flahive, Ogden, & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 20, 2014	99203, 95886, 95911, A4556	\$863.96	\$0.00

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - V292 – Documented procedure does not appear to match the code description of the CPT code billed.

- B291 – This is a bundled or non-covered procedure based on Medicare guidelines; no separate payment allowed.
- U301 – This item was previously submitted and reviewed with notification of decision issued to payor, provider (duplicate invoice).
- ZD86 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Are the insurance carrier’s reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.203 (b) 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;.” Review of submitted medical documentation finds;
 - a. Procedure Code 95911 has a description of “Nerve conduction studies; 9-10 studies”. The Medicare payment policy, LCD ID, L32723, LCD Title Nerve Conduction Studies and Electromyography, states, “Nerve Conduction Studies and Electromyography. Each descriptor (code) from codes 95907, 95908, 95909, 95910, 95911, 95912, and 95913 can be reimbursed **only once per nerve, or named branch of a nerve, regardless of the number of sites tested or the number of methods used on that nerve.** For instance, testing the ulnar nerve at wrist, forearm, below elbow, above elbow, axilla and supraclavicular regions will all be considered as a single nerve. Motor and sensory nerve testing are considered separate tests.” The medical record supports only 8 studies.
 - b. Procedure Code A4556 is a bundled code. No separate payment is allowed.
2. The Carrier’s denials are supported. No additional payment can 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 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 13, 2015 Date
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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, 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 MFDR 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.