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
Orthotexas Physicians and Surgeon

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-15-3027-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 18, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These charges are compensable per the injury."

Amount in Dispute: $440.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden, & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 30, 2014	95910	$440.00	$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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical claims.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 11 – Service not furnished directly to the patient and/or not documented
   - BL – This bill is a reconsideration of a previously reviewed bill

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. The insurance carrier denied disputed services with claim adjustment reason code 11 – "Service not furnished directly to the patient and/or not documented." 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 the Medicare payment policy, http://www.cms.gov, LCD ID, L32723, LCD Title, Nerve Conduction Studies and Electromyography, finds, "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 submitted code 95910 has a description of, "Nerve conduction studies; 7-8 studies." Based on the medical record (Page two of document titled "Test Date: 7/30/2014" included with this dispute, five studies are supported. The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended as documentation does not support 7-8 studies per code billed.

2. The Division finds the requirements of Rule 134.203 (b) as it relates to coding was not met. 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

		July , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

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.