



**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**

MARIA A DE JESUS, MD

**Respondent Name**

LIBERTY MUTUAL FIRE INSURANCE

**MFDR Tracking Number**

M4-15-3076-01

**Carrier's Austin Representative**

Box Number 01

**MFDR Date Received**

MAY 21, 2015

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Our charges for Electromyography & Nerve Conductive Studies have been submitted X 2 with medical notes and data studies of test performed. Our charges have been denied stating medical does not support level of service. We have supplied Liberty Mutual Insurance with ALL medical documents available for the services performed."

**Amount in Dispute:** \$631.00

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "CPT 95911 (Nerve conduction studies; 9-10 studies) was denied as Documentation does not support level of service billed."

**Response Submitted by:** Liberty Mutual Insurance

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 17, 2015	CPT Code 95911 Nerve Conduction Studies (9-10)	\$631.00	\$0.00

**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, sets the reimbursement guidelines for the disputed service.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - X901-Documentation does not support level of service billed.
  - X263-The code billed does not meet the level/description of the procedure performed/documented.

Consideration will be given with coding that reflects the documented procedure.

- X358-Documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge.
- 193-Oringal payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

**Issues**

Does the submitted documentation support billing CPT code 95911?

**Findings**

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."

The American Medical Association (AMA) Current Procedural Terminology (CPT) defines code 95911 as "Nerve conduction studies; 9-10 studies."

Per Medicare guidelines sensory conduction testing, motor conduction testing (with or without F wave testing) or H-reflex testing are each considered a single conduction study. The submitted medical report supports 8 conduction studies; therefore, the requestor's documentation did not support billing CPT code 95911. As a result, reimbursement is not 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**

_____	_____	06/11/2015
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.**