



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

Genesis Medical Management Solutions

Respondent Name

Old Republic General Insurance Corp

MFDR Tracking Number

M4-16-2205-01

Carrier's Austin Representative

Box Number 44

MFDR Date Received

March 29, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance with TDI-DWC Rule 133 and 134."

Amount in Dispute: \$503.58

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CV reductions are upheld. Regarding 95912, provider has billed for 11-12 nerve conduction tests and only 10 are documented. Regarding A4556, supplies normally used to complete the nerve conduction study should not be billed separately."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|------------------|----------------------------|-------------------|------------|
| August 27, 2015 | 99203, 95886, 95912, A4556 | \$503.48 | \$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:
 - 11 – (112) Service not furnished directly to the patient and/or not documented
 - 15 – (150) Payer deems the information submitted does not support this level of service

- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- Z710 – The charge for this procedure exceeds the fee schedule allowance

Issues

1. Are the insurance carrier’s reasons for denial or reduction of payment supported?
2. What is the applicable rule pertaining to fee guidelines?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied submitted code 95912 with the claim adjustment reason code “11 – (112) service not furnished directly to the patient and/or not documented” and code A4556 as “97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.” 28 Texas Administrative Code §134.203 (b) states,

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;

- i. Procedure Code 95912 - Nerve conduction studies; 11 – 12 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.” Based on the above and the submitted medical records the number of tests described by submitted code is not supported.
- ii. Procedure Code A4556 is a bundled code inclusive of the primary procedure. No separate payment can be recommended.

2. 28 Texas Administrative Code §134.203 (c) “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 (date of service yearly conversion factor).” The maximum allowable reimbursement will be calculated as follows; (DWC Conversion Factor/Medicare Conversion Factor) x allowable = TX Fee MAR or

$$56.2/35.9335 \times \$110.64 = \$173.04$$

3. The total allowable reimbursement for the services in dispute is \$173.04. This amount less the amount reported amount paid by the insurance carrier of \$173.05 leaves an amount due to the requestor of \$0.00. No additional reimbursement 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

April , 2016
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.