



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

MARC D. PECHA, MD

**Respondent Name**

HARTFORD ACCIDENT & INDEMNITY

**MFDR Tracking Number**

M4-16-2215-01

**Carrier's Austin Representative**

Box Number 47

**MFDR Date Received**

MARCH 30, 2016

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Corvel is denying for studies performed not documented. Attached are...notes to show that the studies on progress note were performed."

**Amount in Dispute:** \$1,239.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** The respondent did not submit a response to this request for medical fee dispute resolution.

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 21, 2015	CPT Code 95912 Nerve Conduction Studies (11-12)	\$1,239.00	\$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, 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:
  - B12-Svcs not documented in patient record.
  - 97-Charge included in another charge or service.
  - W3-Appeal/Reconsideration.
- The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on April 7, 2016. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not

submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

**Issues**

Does the documentation support billing of code 95912?

**Findings**

The respondent denied reimbursement for the nerve conduction studies based upon reason code “B12-Svcs not documented in patient record”.

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.”

CPT code 95912 is defined as a 11-12 nerve conduction studies. There are three types of nerve conduction studies that are represented by these codes: sensory conduction, motor conduction (with or without an F wave test), or an H-reflex test. Each nerve conduction study is reported only once per nerve even when multiple sites of the same nerve are studied.

A review of the submitted medical report supports 5 studies; therefore, the requestor did not support billing CPT code 95912. As a result, reimbursement is not recommended

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due for the specified services. 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

\_\_\_\_\_  
05/18/2016

**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.**