



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

Cesar Pierre Duclair

Respondent Name

WC Solutions

MFDR Tracking Number

M4-16-3116-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

June 13, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The service provided for EMG/NCV includes an office consultation for this date of service. Per the attached report an office consult was performed as part of making an accurate diagnosis for this examinee with regards to the performance of the testing and used in making a final determination. The examination is correlated with clinical findings performed as part of the office consultation. It is documented and bill appropriately."

Amount in Dispute: \$285.23

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "There is no documentation that an evaluation or consult was requested by the designated doctor... HCPCS code A4556 was denied with CARC reduction code of P14. When electrodes are incident to a physician's service, they are not separately payable."

Response Submitted by: Edwards Claims Administration

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: November 11, 2015, 99204, A4556, \$285.23, \$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 §127.10 sets out general procedure for Designated Doctor Examinations.
3. 28 Texas Administrative Code §134.203 sets out the billing requirements for professional services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 165 – Payment denied/reduces for absence of, or exceeded referral
 - P14 – The benefit for this service is included in the payment/allowance for another service/procedure that has been performed on the same day.
 - W3 – Additional reimbursement made on reconsideration
 - 193 – Original payment decision is being maintained. This claim was processed properly the first time

Issues

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

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 165 – “Payment denied/reduced for absence of, or exceeded referral 28 Texas Administrative Code §127.10 (c) states in pertinent part,

The designated doctor shall perform additional testing when necessary to resolve the issue in question. The designated doctor shall also refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question and the designated doctor is not qualified to fully resolve the issue in question. Any additional testing or referral required for the evaluation is not subject to preauthorization requirements nor shall those services be denied retrospectively based on medical necessity, extent of injury, or compensability...

Review of the submitted documentation from the requestor finds document titled, “Electromyography (EMG) Report” under Purpose of examination/referring party: “The above examinee was referred for Electromyography Testing (EMG/NCV) by the above listed referring party.” Pursuant to 28 Texas Administrative Code 127.10 (c) a referral for an evaluation was required. Insufficient evidence to support a referral for any service other than EMG/NCV was found. The carrier’s denial is supported.

The carrier denied code A4556 as 97 – “The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.” Review of Code A4556 status finds “P” or excluded as incident to a physician’s service (not separately payable).” As this service is incident to the Needle EMG/Nerve Conduction Study, the carrier’s denial is supported.

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 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July , 2016 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.