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
DALLAS TESTING, INC

Respondent Name
ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number
M4-18-5094-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
AUGUST 21, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The above date of service was not paid and has been returned due to reason: 'Authorization required but not requested.' This is incorrect. Per TWCC rule 134.600(p)(8) preauthorization is required for a REPEAT individual diagnostic study. This is an initial EMG, not a repeat. Preauthorization is not required."

Amount in Dispute: $592.66

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
February 5, 2018	CPT Code 95912	$439.61	$439.61
	CPT Code 95886	$153.05	$153.05
TOTAL		$592.66	$592.66

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, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.600, effective March 30, 2014, requires preauthorization for specific treatments and services.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment code:
   - 197-Percertificaiton/authorization/notification absent.
   - W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. What is the applicable fee guideline for professional services?
2. Is the denial of payment for physical therapy services supported?
3. Is the requestor entitled to reimbursement?

Findings

1. The fee guidelines for disputed services is found at 28 Texas Administrative Code §134.203.
2. On the disputed dates of service, the requestor billed CPT codes 95912 and 95886

   According to the explanation of benefits, the respondent denied reimbursement for CPT codes 95912 and 95886 based upon a lack of preauthorization.

   Per 28 Texas Administrative Code §134.600(p)(8)(A-B) the non-emergency healthcare that requires preauthorization includes: "(8) unless otherwise specified in this subsection, a repeat individual diagnostic study: (A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline; or (B) without a reimbursement rate established in the current Medical Fee Guideline."

   The requestor wrote, "This is an initial EMG, not a repeat. Preauthorization is not required."

   The division finds no evidence that the disputed NCV/EMG were repeat tests; therefore, the respondent's denial of payment based upon a lack of authorization is not supported.
3. Per 28 Texas Administrative Code §134.203(c)(1)(2), "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 $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 75211, which is in Dallas, Texas; therefore, the Medicare participating amount is based on locality "Dallas, Texas".

   The 2018 DWC conversion factor for this service is 58.31.

   The Medicare conversion factor is 35.9996.

   The Medicare participating amount for code 95912 in Dallas, TX is $271.41 and $94.49 for 95886.

Using the above formula, the Division finds the MAR is $439.61 for 95912 and $153.05 for 95886. The respondent paid $0.00. The requestor is due the difference of $592.66.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $592.66.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $592.66 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		11/12/2018
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.