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
JAMES CARLISLE, MD

Respondent Name
ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number
M4-19-2692-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JANUARY 15, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The above dates of service were not paid in full and had been returned due to reason: 'Precertification/authorization/notification absent.' This is incorrect. **Per TWCC rule 134.600(p)(8) pre authorization is required for a REPEAT individual diagnostic study**."

Amount in Dispute: $549.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the carrier has reprocessed the provider's bill. Please note that the provider's DWC-60 requested reimbursement of $549.40. The carrier's attached EOB dated February 15, 2019 recommends reimbursement of $549.40."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 20, 2018	CPT Code 95886 Needle EMG	$153.05	$0.00
	CPT Code 95911 Nerve Conduction Studies	$396.35	$0.00
TOTAL		$549.40	$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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced / denied by the respondent with the following reason code:
   - 197-Precertification/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

Is the requestor entitled to reimbursement for CPT codes 95886 and 95911?

Findings

1. The requestor is seeking dispute resolution for $549.40 for CPT codes 95911 and 95886. According to the explanation of benefits, the respondent initially denied reimbursement for these codes based upon a lack of preauthorization; however, upon reconsideration the respondent did not maintain the denial and recommended payment of $549.40.
2. The fee guidelines for disputed services are found in 28 Texas Administrative Code §134.203.
3. 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."
4. 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).

   The 2018 DWC conversion factor for this service is 58.31.

   The Medicare Conversion Factor is 35.9996

   Review of Box 32 on the CMS-1500 the services were rendered in Dallas, Texas.

Using the above formula, the division finds:

CODE	MEDICARE PARTICIPATING AMOUNT	MAR	INSURANCE CARRIER PAID	AMOUNT DUE
95911	$244.70	$396.35	$396.35	$0.00
95886	$94.49	$153.05	$153.05	$0.00

Conclusion

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

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

		03/21/2019
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.