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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
DALLAS TESTING, INC

Respondent Name
AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number
M4-19-3214-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
FEBRUARY 20, 2019

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) pre authorization is required for a REPEAT individual diagnostic study."

Amount in Dispute: $485.31

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the carrier's position that preauthorization was required for the diagnostic testing done on September 17, 2018. Thus, the provider is not entitled to reimbursement."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 17, 2018	CPT Code 95910 Nerve Conduction Studies (7-8 Studies)	$332.26	$0.00
	CPT Code 98886 Needle Electromyography, Each Extremity	$153.05	$0.00
TOTAL		$485.31	$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, 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 §137.100, effective January 18, 2007, sets out the use of the treatment guidelines.
4. The services in dispute were reduced/denied by the respondent with the following claim adjustment reason codes:
    - 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 due reimbursement for CPT codes 95910 and 95886 rendered on September 17, 2018?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for CPT codes 95910 and 95886 based upon "197-Precertification/authorization/notification absent."
2. 28 Texas Administrative Code §134.600(p)(12) requires preauthorization for "treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier."
3. According to the Knee and Leg Chapter of the Official Disability Guidelines (ODG), a nerve conduction needle EMG study is not a recommended procedure; therefore, the disputed services required preauthorization.
4. There is no evidence submitted, that the requestor obtained preauthorization in accordance with 28 Texas Administrative Code §134.600(p)(12). As a result, a preauthorization issue exists and reimbursement is not 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

		4/18/2019
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.