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
THE CLINIC OF NORTH TEXAS, LLP

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-19-3264-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
FEBRUARY 25, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The documentation for the studies was included with the appeal."

Amount in Dispute: $288.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The documentation demonstrated testing of the right median motor and sensory nerve and testing the right ulnar motor and sensory nerve, a total of four nerves. The requester billed 95909, 5-6 studies. No payment is due."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 9, 2018	CPT Code 95909 Nerve Conduction Studies	$288.00	$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

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:
   - CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.

- CAC-16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 225-The submitted documentation does not support the service being billed, we will re-evaluate this upon receipt of clarifying information.
- 714-Accurate coding is essential for reimbursement, CPT/HCPCS billed incorrectly. Corrections must be submitted w/I 95 days from DOS.
- 891-No additional payment after reconsideration.
- CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Does the documentation support billing CPT code 95909 in accordance with 28 Texas Administrative Code §134.203?

Findings

According to the submitted explanation of benefits, the respondent denied reimbursement for CPT code 95909 based upon a lack of documentation, billing errors, and incorrect coding.

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 95909 is described as "Nerve conduction test, 5-6 studies."

A review of the submitted medical report supports (redacted) for a total of 4; therefore, the documentation does not support billed service. 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.

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

		03/28/2019
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.