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 COMPANY

MFDR Tracking Number
M4-19-3759-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 10, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is an initial EMG, not a repeat. Preauthorization is not required. Please see attached documentation to see rule. Therefore, this claim should be PAID IN FULL to prevent IRO..."

Amount in Dispute: $485.31

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier denied the medical bill on the basis that preauthorization was not requested. The provider's response is that since the diagnostic study was not a repeat individual diagnostic study, preauthorization was not required... Any services in excess of the ODG require preauthorization. In our case, the provider did not request preauthorization. The provider is not entitled to reimbursement."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
September 19, 2018	95910 and 95886	$485.31	$485.30

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 §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197-Precertification/authorization/notification absent

Issue(s)

1. Is the denial of payment for CPT Code 95910 and 95886 supported?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Codes 95910 and 95886 rendered on September 19, 2018. The insurance carrier denied the disputed service with denial reduction code "197— Precertification/authorization/notification absent.

   28 Texas Administrative Code §134.600(p)(8)(A-B) states that 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 states in part, "This is an initial EMG, not a repeat. Preauthorization is not required."

   The division finds insufficient evidence that the disputed CPT Codes 95910 and 95886 were repeat tests; therefore, the respondent's denial of payment based upon a lack of authorization is not supported. The disputed service is therefore eligible for review pursuant to applicable rules and guidelines.

2. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) 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..."

   - Procedure code 95910, rendered on September 19, 2018, has a Work RVU of 2 multiplied by the Work GPCI of 1.012 is 2.024. The practice expense RVU of 3.54 multiplied by the PE GPCI of 1.014 is 3.58956. The malpractice RVU of 0.11 multiplied by the malpractice GPCI of 0.768 is 0.08448. The sum is 5.69804 multiplied by the DWC conversion factor of $58.31 for a MAR of $332.25. Therefore, this amount is recommended.
   - Procedure code 95886, rendered on September 19, 2018, has a Work RVU of 0.86 multiplied by the Work GPCI of 1.012 is 0.87032. The practice expense RVU of 1.7 multiplied by the PE GPCI of 1.014 is 1.7238. The malpractice RVU of 0.04 multiplied by the malpractice GPCI of 0.768 is 0.03072. The sum is 2.62484 multiplied by the DWC conversion factor of $58.31 for a MAR of $153.05. Therefore, this amount is recommended.

3. Review of the submitted documentation finds that the requestor is entitled to a total reimbursement amount of $485.30. Therefore, this amount is recommended.

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 $485.30.

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 $485.30 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 15, 2019 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.