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
M4-20-1232-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JANUARY 17, 2020

REQUESTOR'S POSITION SUMMARY

"The above date of service was not paid and has been returned due to reason: 'Services not documented.' This is incorrect. **95886** is the code used to bill for the **ELECTROMYOGRAPHY** when **5 or more muscles are tested**. There were 5 muscles performed and recorded in the report."

Amount in Dispute: $156.91

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
May 21, 2019	CPT Code 95886(X2) Needle EMG	$156.91	$0.00
	CPT Code 95910 Nerve Conduction Studies	$0.00	$0.00
TOTAL		$156.91	$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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §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(s):
   - 112-Service not furnished directly to the patient and/or not documented.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - W3-Request for reconsideration.

Issues

Is the requestor eligible for reimbursement for CPT code 95886 rendered on May 21, 2019?

Findings

1. The Austin carrier representative for Zurich American Insurance Co is Flahive Ogden & Latson. Flahive Ogden & Latson acknowledged receipt of the copy of this medical fee dispute on January 24, 2020. §133.307(d)(1) states that if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information

   As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under 28 TAC §133.307(d)(1).
2. The requestor is seeking medical fee dispute resolution in the amount of $156.91 for CPT code 95886 rendered on May 21, 2019.
3. The respondent denied reimbursement for CPT code 95886 based upon reason code "112-Service not furnished directly to the patient and/or not documented."
4. The fee guidelines for disputed services are found in 28 Texas Administrative Code §134.203.

   28 TAC §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."
5. CPT code 95886 is described as "Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure)."
6. A review of the submitted report does not document "five or more muscles studied, innervated by three or more nerves or four or more spinal levels" to support billing CPT code 95886. As a result, reimbursement is not recommended.

Conclusion

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

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		03/04/2020
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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **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.