TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Martinez, Alejandro Thomas

**Respondent Name**
New Hampshire Insurance Co

**MFDR Tracking Number**
M4-12-2392-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
March 19, 2012

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "F-wave studies are a separate and billable service not to be bundled with another nerve study."

**Amount in Dispute:** $270.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The Carrier pays for testing on major nerves, one unit despite multiple testing on the nerves that branch of the other nerves."

**Response Submitted by:** Chartis

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| September 21, 2011 | 95900 | $270.00 | $0.00 |

## *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 §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 150 – Payer deems the information submitted does not support this level of service
   - 97 – The benefit for this service is included in the payment/allowance for another service
   - This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed

**Issues**

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

**Findings**

1. The insurance carrier denied disputed services with claim adjustment reason code 97 – "The benefit for this service is included in the payment/allowance for another service." 28 Texas Administrative Code §134.203(b) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; "

   Review of the National Correct Coding Initiative Policy Manual for Medicare services, Chapter 11 finds, "The NCCI edit with column one CPT code 95903 (Motor nerve conduction studies with F-wave study, each nerve) and column two CPT code 95900 (Motor nerve conduction studies without F-wave study, each nerve) is often bypassed by utilizing modifier 59. Use of modifier 59 with the column two CPT code 95900 of this NCCI edit is appropriate only if the two procedures are performed on different nerves or at separate patient encounters."

   Review of the submitted medical documentation finds the same muscles listed for both the "Motor Summary Table" and "F Wave Studies. The Division finds the insurance carrier's denial reason is supported.

2. Pursuant to Rule 134.203 (b) no additional reimbursement can be 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**

| | | |
|---|---|---|
| | | September , 2015 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MFDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of this *Medical Fee Dispute Resolution Findings and Decision***, together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.