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
Liberty Insurance Corp

MFDR Tracking Number
M4-15-1875-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
February 20, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted by the requestor.

Amount in Dispute: $661.81

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Code 95869: This study is not documented in the report. Code A4215 is a supply code and is not separately reimbursable under Medicare Guidelines."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 2, 2014	95913, 95886, 95869, A4215	$627.58	$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:
   - X901 – Documentation does not support level of service billed
   - U630 – Procedure code not separately payable under Medicare and-or fee schedule guidelines
   - 193 – Original payment decision is being maintained

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 submitted code 95913 and 95869 with claim adjustment reason code "X901 – Documentation does not support level of service billed" and code A4215 as "U630 – Procedure code not separately payable under Medicare and-or fee schedule guidelines." 28 Texas Administrative Code §134.203 (b) 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 submitted medical documentation finds;
    a. Procedure Code 95913 has a description of "Nerve conduction studies; 13 or more studies". The Medicare payment policy, LCD ID, L32723, LCD Title Nerve Conduction Studies and Electromyography, states, "Nerve Conduction Studies and Electromyography. Each descriptor (code) from codes 95907, 95908, 95909, 95910, 95911, 95912, and 95913 can be reimbursed **only once per nerve, or named branch of a nerve, regardless of the number of sites tested or the number of methods used on that nerve**. For instance, testing the ulnar nerve at wrist, forearm, below elbow, above elbow, axilla and supraclavicular regions will all be considered as a single nerve. Motor and sensory nerve testing are considered separate tests." Based on the above the medical record supports only 10 studies. The Carrier's denial is supported.
    b. Procedure Code 95869 has a description of "95869, Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)". Review of the submitted medical record finds report documents results from primarily the upper extremities. No results were found for thoracic testing. The Carrier's denial is supported.
    c. Procedure Code A4215 is a supply code inclusive of the primary procedure. No separate payment can be recommended.
2. The Carrier's denials are supported. No additional payment 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

		May 4, 2015
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.