TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Principle Diagnostics LLC

Respondent Name
Vanliner Insurance Co

MFDR Tracking Number
M4-24-2312-01

Carrier's Austin Representative
Box Number 06

DWC Date Received
June 19, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 31, 2023	95886, 95887, 95911, 95937, A4554, A4556, A4558, A4215, A4245, and A4927	$1,670.00	$983.07
	Total	$1,670.00	$983.07

Requestor's Position

"We initially billed this claim within the timely filing limits. We got denied. The original denial is on this dispute, explanation of review dated 12/15/2023. The denial stated extent of injury. We got approval from Careworks and adjuster before we administered this test."

Amount in Dispute: $1,670.00

Respondent's Position

"Vanliner does not accept either of those diagnoses as a compensable condition. Accordingly, it denied payment with the following explanation: Extent of injury. Treatment is unrelated to the compensable injury. Claim has not yet been adjudicated… Because the request involves an unresolved extent of injury dispute, it is not ripe for MDFR."

Response Submitted by: Stone Loughlin Swanson

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 TAC §124.2 sets out the requirements of insurance carrier notifications.
4. 28 TAC §134.203 sets out the fee guideline for professional medical services
5. 28 TAC §133.20 sets out the medical bill submission procedures for health care providers.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 29 – The time limit for filing has expired.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- R51B – The procedure does not fall within the Medicare multiple procedure guidelines, therefore recommended payment based on 100% of the allowed amount for the procedure billed or the billed amount, whichever is less.
- Note: Extent of injury. Treatment is unrelated to the compensable injury. Claim has not yet been adjudicated.

Issues

1. Did the insurance carrier support the denial of extent of injury?
2. Is the insurance carrier's denial of timely filing supported?
3. What rule is applicable to reimbursement?
4. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement in the amount of $1,670.00, for diagnostic services rendered on October 31, 2023. The insurance carrier denied the disputed services due to the extent of injury.

   DWC Rule 28 TAC §133.307(d)(2)(H) requires that if the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with Rule §124.2 (relating to carrier reporting and notification requirements).

   DWC Rule 28 TAC §124.2(h) requires notification to the division and claimant of any dispute of

disability or extent of injury using plain language notices with language and content prescribed by the division. Such notices "shall provide a full and complete statement describing the carrier's action and its reason(s) for such action. The statement must contain sufficient claim-specific substantive information to enable the employee/legal beneficiary to understand the carrier's position or action taken on the claim."

Review of the submitted information finds no copies, as required by Rule §133.307(d)(2)(H), of any PLN-11 or PLN 1 notices issued in accordance with Rule §124.2. The insurance carrier's denial reason is therefore not supported. Furthermore, because the respondent failed to meet the requirements of Rule §133.307(d)(2)(H) regarding notice of issues of extent of injury, the respondent has waived the right to raise such issues during dispute resolution. Consequently, the division concludes there are no outstanding issues of compensability, extent, or liability for the injury. The disputed services are therefore reviewed pursuant to the applicable rules and guidelines.

2. The insurance carrier denied the disputed services due to 95-day timely filing issues. DWC Rule 28 TAC §133.20(b) requires that, except as provided in TLC §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

   The submitted explanation of benefits indicates the medical bill was received by the carrier on December 12, 2023. This date of receipt is within 95 days of the date of service October 31, 2023. The denial for timely filing in not supported.

3. The requestor is seeking reimbursement of the following professional medical services that are subject to provisions of DWC Rule 28 TAC §134.203 (b) which states in pertinent parts, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   DWC Rule 28 Texas Administrative Code §134.203(c)(1) states, "…To determine to MAR for professional services, system participants shall apply the Medicare payment policies with minimal modification…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 $53.68…"

   The following formula represents the calculation of the DWC MAR at §134.203 (c)(1) & (2).

   (DWC Conversion Factor ÷ Medicare Conversion Factor) x Medicare Payment = MAR

   Applicable 28 TAC 134.203(h) states that the total reimbursement is the lesser of the maximum allowable reimbursement (MAR) and the billed amount.

   - 95886 – Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or mor muscles studies, innervated by three or mor nerves or four or mor spinal levels. The physician fee schedule allowable for locality (Houston) is $100.58 x 64.83/33.8872 = $192.42

- 95887 Needle electromyography, non-extremity (cranial nerve supplies or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study. The physician fee schedule allowable for locality (Houston) is $86.4 x 64.83/33.8872 = $165.35.
- 95911 - Nerve conduction studies; 9-10 studies. The physician fee schedule allowable for locality (Houston) is $218.01 x 64.83/33.8872 = $417.08.
- 95937 – Neuromuscular junction testing (repetitive stimulation, paired stimuli) each nerve, any 1 method. The physician fee schedule amount for locality (Houston) $208.22 X 64.83/33.8872 = $208.22
- A4554 – Disposable underpads – Non-covered service no payment recommended.
- A4556 – Electrodes per pair – Bundled excluded code no payment recommended.
- A4558 – Conductive gel or paste - Bundled excluded code no payment recommended.
- A4215 – Needle, sterile, any size each – Statutory excluded no payment recommended.
- A4245 – Alcohol wipes, per box – Statutory excluded no payment recommended.
- A4927 – Gloves, nonsterile, per 100 – Statutory excluded no payment recommended.

4. The total MAR for the disputed service is $983.07. This amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The DWC finds the requester has established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Vanliner Insurance Co must remit to the Principle Diagnostics LLC $983.07 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		July 22, 2024
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC along with a **copy** of the ***Medical Fee Dispute Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.