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
M4-24-2611-01

Carrier's Austin Representative
Box Number 6

DWC Date Received
July 29, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 15, 2023	95886-LT	$225.00	$192.42
November 15, 2023	95887-LT	$200.00	$165.35
November 15, 2023	95911-LT	$950.00	$417.08
November 15, 2023	95937-LT	$280.00	$208.22
November 15, 2023	A4215	$25.00	$0.00
November 15, 2023	A4556	$25.00	$0.00
	Total	$1705.00	$983.07

Requestor's Position

"We initially billed this claim within the timely filing limits as you can see from the eob denial dated 2/8/2024. We got denied because the insurance carrier was stating we used a diagnosis code that did not exist, however on the denied [sic] dated 2/8/2024 the diagnosis code we used is on there and it does not match the one on the cover page where the carrier listed diagnosis code (redacted) was used."

Amount in Dispute: $1,705.00

Respondent's Position

"Carrier relies on the audit performed and for the additional reason that the services provided

were for conditions disputed by the carrier as not related to the work injury, which dispute was validated by the Designated Doctor. It is the carrier's position that the fees billed are not owed. A copy of the Designated Doctor's report is attached to this response.

Response submitted by: Stone Laughlin 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, effective February 22, 2021, 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. 28 TAC §124.2 details requirements of plain language notices.

Denial Reasons

- 18 – Exact duplicate claim/service
- D – Service has previously been submitted.
- 29 – The time limit for filing has expired
- **Tue, July 9 2024 15:05 PM **Extent of injury. Treatment is not related to the compensable injury/injuries. Claim has not yet been fully adjudicated.

Issues

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

Findings

1. The requestor is seeking reimbursement of professional medical services rendered in November of 2023. The insurance carrier included a message on the explanation of benefits stating treatment not related to compensable 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 requestor is seeking medical fee dispute resolution in the amount of $1705.00 for CPT codes 95886-LT, 95887-LT, 95911-LT5 95937, A4556 and A4215 rendered on November 15, 2023. The insurance carrier denied reimbursement based on timely filing. Review of the submitted documentation found a document dated January 17, 2024 from CareWorks that acknowledged receipt of the disputed medical bill. This date is within 95 days from the date of service. The insurance carrier's denial for timely filing not supported.

3. The fee guidelines for disputed services are found in DWC Rule 28 TAC §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).

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

   - 95886 - Musc test done w/n test comp $100.58 (location Houston) x 64.83/33.8872 = $192.42
   - 95887 – Musc test done w/n test nonext $86.43 (location Houston) x 64.83/33.8872 = $165.35
   - 95911 – Nrv cndj test 9-10 studies $218.01 (location Houston) x 64.83/33.8872 = $417.08
   - 95937 – Neuromuscular junction test $108.84 (location Houston) x 64.83/33.8872 = $208.22

- HCPCS code A4556 is defined as "Electrodes (e.g., apnea monitor), per pair." Per Medicare physicians' fee schedule, code A4556, is a status "P" code. Status "P" codes are defined as "Bundled/excluded codes. No separate payment is made for them under the fee schedule.
- HCPCS code A4215 is defined as "Needle, sterile, any size, each." Per Medicare guidelines, Transmittal B-03-020, effective February 28, 2003 if Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) HCPCS codes are incidental to the physician service, it is not separately payable. A review of the submitted documentation does not support a separate service to support billing HCPCS code A4215 in conjunction with CPT codes 95886 and 95911. As a result, reimbursement is not recommended.

4. The total allowable 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.

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

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Vanliner Insurance Co must remit to 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

Signature	Medical Fee Dispute Resolution Officer	September 5, 2024 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, please 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. **Please include a copy of the *Medical Fee Dispute Resolution 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.