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
Jeffrey B. Gibberman, MD

Respondent Name
Insurance Company of the West

MFDR Tracking Number
M4-25-0494-01

Carrier's Austin Representative
Box Number 04

DWC Date Received
October 29, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 25, 2024	95886-LT	$225.00	$197.35
March 25, 2024	95910-LT	$850.00	$361.04
March 25, 2024	A4215	$50.00	$0.00
March 25, 2024	A4245	$20.00	$0.00
March 25, 2024	A4556	$25.00	$0.00
March 25, 2024	A4558	$25.00	$0.00
	Total	$1,195.00	$558.39

Requestor's Position

"We tested the patient and have not been able to get reimbursed. When I spoke to the bill payment company, they indicated that they recommended an amount, but the adjuster had put a stop to the payment. Upon speaking to adjuster, she informed our staff that because the word [injury] is listed on the finalized report that the payment was not processed, and we have to wait for litigation to see if [injury] is included on the claim. The word [injury] is only listed on the report for a recommendation for… imaging not that we tested… We then asked if there were any appeal rights and were told no."

Amount in Dispute: $1,195.00

Respondents' Position

The Austin carrier representative for Insurance Company of the West is Law Office of Ricky D. Green. The representative was notified of this medical fee dispute on November 5, 2024. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division 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 §133.307(d)(1).

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §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) §133.305 sets out the procedures for resolving medical disputes.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 TAC §134.203 sets out the fee guideline for professional medical services.
4. 28 TAC §124.2 sets out the insurance carrier notification requirements.

Denial Reasons

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

- 11 – The diagnosis is inconsistent with the procedure.
- 229 – Procedure does not appear related to the injury and/or diagnosis. We will re-evaluate this charge upon receipt of clarifying information.
- 97 – The benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated.
- G15 – Pricing is calculated based on the medical professional fee schedule value.
- H45 – No allowance was recommended as this procedure has a Medicare status of "P" bundled/excluded.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Did the insurance carrier support the extent of injury denial?
2. What rules are applicable to the billing of the disputed medical services?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement in the amount of $1,195.00, for medical services rendered on March 25, 2024. 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."

   A review of the submitted documentation finds no copies, as required by Rule §133.307(d)(2)(H), of either 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), the respondent has waived the right to raise such issues during medical fee dispute resolution. Consequently, the division concludes there are no outstanding issues of the extent of injury. The disputed services are therefore reviewed pursuant to the applicable rules and guidelines.

2. The requestor is seeking reimbursement of the following professional medical services, subject 28 TAC §134.203(a)(5), "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."

   28 TAC §134.203(b)(1) 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; 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."

   To determine whether the requestor is entitled to reimbursement of the disputed services, the DWC completed NCCI edits of the medical charges rendered on March 25, 2024. The requestor billed the following CPT codes and modifiers.

   - LT- Left side
   - 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 requestor rendered the services as billed. Reimbursement is therefore recommended.

- 95910 - Nerve conduction studies; 7-8 studies. The requestor rendered the services as billed. Reimbursement is therefore recommended.
- A4215 – Needle, sterile, any size each – Statutory excluded no payment recommended.
- A4245 – Alcohol wipes, per box – Statutory excluded no payment recommended
- A4556 – Electrodes per pair – Bundled excluded code no payment recommended.
- A4558 – Conductive gel or paste - Bundled excluded code no payment recommended.

The DWC determines that the A codes billed on March 25, 2024 contain edit conflicts and are identified as bundled and/or statutorily excluded services. As a result, reimbursement is not suggested for the A codes.

The DWC determines that the requestor is eligible for reimbursement of CPT codes 95886 and 95910. The reimbursement is determined below.

3. 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 formula for determining the MAR is as follows: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

- Date of service in dispute: March 25, 2024
- The 2024B DWC Conversion Factor is 67.81
- The 2024B Medicare Conversion Factor is 33.2875
- A review of the medical bills finds that the disputed services were rendered in zip code 77007; the Medicare locality is "Rest of Texas."
- Place of service "11"-Office Setting

- The Medicare Participating amount for one unit of CPT code 95886 at this locality is $96.88.
- Using the above formula, the DWC finds the MAR is $197.35.
- The requester seeks $225.00.
- The respondent paid $0.00.
- Reimbursement of $197.35 is recommended.

- The Medicare Participating amount for one unit of CPT code 95910 at this locality is $177.23.
- Using the above formula, the DWC finds the MAR is $361.04.
- The requester seeks $850.00.
- The respondent paid $0.00.
- Reimbursement of $361.04 is recommended.

The DWC finds that the requestor is entitled to a total recommended reimbursement of $558.39 for the medical services rendered on March 25, 2024.

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 requestor 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 respondent must remit to the requestor $558.39 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		February 7, 2025
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. **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.