



## MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address: Advanced Medical Associates P.O. Box 1895 Deer Park, TX 77536	MDR Tracking No.: M4-05-1487-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Old Republic Insurance Co. C/o ECAS Box 02	Date of Injury:
	Employer's Name: Fox Service Company, Inc.
	Insurance Carrier's No.: 0R03EG02140001

### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Requestor's position summary states in part, "...Please note that the carrier has not paid the entire fee schedule for services 95904, 95903, and 95934 as rendered in Travis County. Additionally, carrier has denied 95861 as not within the scope; however, per Texas Board it is within the scope. The carrier has paid for these services in the past. Additionally, you should note that the TWCC designated doctor ordered these services..."

Principle Documentation:

1. Requestor's position summary
2. HCFA 1500's
3. TBCE letters of clarification
4. EOB's

### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent's position summary states in part, "...The diagnostic service performed on 12/04/03, (code 95861) was performed by a chiropractor. Code 95861, a needle EMG, was denied as not in the scope of practice for a doctor of chiropractic based upon SOAH Docket 453-01-1615.M4 where the judge ruled that in accordance with Texas Occupational Code 201.202, and the Texas Attorney General Opinion DM-472, a needle EMG is not within the scope of practice of chiropractic, therefore a chiropractor performing a needle EMG is not entitled to reimbursement..."

Principle Documentation:

1. Respondent's position summary

### PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
12/04/03	95861	1	\$131.08
12/04/03	95904, 95903 & 95934	2	\$0.00
TOTAL DUE			\$131.08

### PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Commission Rule 134.202 titled (Medical Fee Guideline) effective August 1, 2003, sets out reimbursement guidelines.

1. CPT Code 95861 for date of service 12/04/03 was denied as "K – Out of the scope of practice for this provider". The Requestor submitted a letter of clarification from the Texas Board of Chiropractor Examiners (TBCE) that documents needle EMGs are within the scope of chiropractic. Therefore, per Rule 134.202(c)(1) reimbursement in the amount of \$131.08 is recommended.

2. CPT Codes 95904, 95903 and 95934 for date of service 08/06/03 was denied as “F – M – Reimbursement based upon the maximum allowable fee for this PX based upon the state medical fee schedule, or if one not specified, UCR for this Zip Code Area” or “F – If reduction, then processed according to the Texas Fee Guidelines.” According to the submitted CMS-1500 the facility where the service was rendered to the injured worker was Round Rock, TX 78681, which is located in Williamson County, Texas, and is considered by Medicare to be in locality 99 (All Other Texas Counties). Per Rule 134.202(b) and (c)(1) insurance carrier has properly reimbursed the Requestor and no additional reimbursement is recommended.

Therefore it is the conclusion of the Medical Review Division that additional reimbursement in the amount of \$131.08 is due the requestor.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 413.011(a-d)  
28 Texas Administrative Code Sec. 134.202

**PART VII: DIVISION DECISION AND ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor is entitled to additional reimbursement in the amount of **\$131.08**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30-days of receipt of this Order.

Ordered by:

Marguerite Foster

January 5, 2006

Authorized Signature

Typed Name

Date of Order

**PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW**

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

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