Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
FOUNDATION ANCILLARY SERVICES AFFILIATES, LLC

Respondent Name
LM INSURANCE CORP

MFDR Tracking Number
M4-11-3150-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
MAY 16, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "All the procedure codes we primarily use 95920, 95925, 95926, 95928, 95929, 95955, 95957, 95861, 51785, and 95900 do not have the Bundling Indicator. Please note according to the National Coding and AMA, these codes are separately billable for the Technical and Professional Component and these codes are separately reimbursable."

Amount in Dispute: $623.82

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill and documentation attached to the medical dispute have been re-reviewed and our position remains unchanged."

Response Submitted by: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 21, 2010	CPT Code 95861-TC-59 Needle EMG	$0.00	$0.00
	CPT Code 95920-TC-59 (X2) Intraoperative Neurophysiology Testing, per hour	$65.52	$0.00
	CPT Code 95925-TC Short-latency somatosensory evoked potential study – Upper Limbs	$151.91	$151.91
	CPT Code 95926-TC Short-latency somatosensory evoked potential study – Lower Limbs	$147.59	$147.59
	CPT Code 99080 Special Report	$15.00	$0.00
	HCPCS Code A4556 (X2) Electrodes, per pair	$18.80	$0.00
	HCPCS Code A4557 (X5) Lead Wires, per pair	$225.00	$0.00

TOTAL		$623.82	$299.50

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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, effective March 1, 2008, *33 Texas Register 364*, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Z710-The charge for this procedure exceeds the fee schedule allowance.
   - X901-Documentation does not support level of service billed.
   - B291-This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed.
   - B327-Please provide explanation of CPT code 99080 for payment. Identify if report is for DWC069, DWC073, copy of records, or progress report. Attach a copy of this EOB with your resubmission.

Issues

1. Does the documentation support billing of second unit of code 95920-TC-59?
2. Is the allowance for CPT code 95925-TC included in the allowance of another service rendered on the disputed date of service?
3. Is the allowance for CPT code 95926-TC included in the allowance of another service rendered on the disputed date of service?
4. Is the requestor entitled to reimbursement for codes 95925-TC and 95926-TC?
5. Is the allowance for HCPCS codes A4556 and A4557 included in the allowance of another service rendered on the disputed date of service?
6. Does the documentation support billing of CPT code 99080?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the second unit of CPT code 95920-TC-59 based upon reason code "X901".

   28 Texas Administrative Code §134.203(a)(5) states "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 Texas Administrative Code §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."

   The American Medical Association (AMA) Current Procedural Terminology (CPT) defines code 95920 as "Intraoperative neurophysiology testing, per hour (List separately in addition to code for primary procedure)."

   The AMA CPT describes code 95920 as "ongoing electrophysiologic testing and monitoring performed during surgical procedures." "The time spent performing or interpreting the baseline electrophysiologic studies should not be counted as intra-operative monitoring, but represents separately reportable procedures."

   A review of the Surgical Monitoring Services report finds that the requestor noted the time when claimant underwent the baseline study and the surgical procedure . This report indicates the following:
   - 10:36:30 Medium SSEP Baselines Set Pre Incision.
   - 10:51:14 Medium Incision.

- 11:18:43 Medium Closing.
- 11:22:20 Medium Closing Skin.

Per the CPT guidelines, the time spent performing or interpreting the baseline studies is not counted. The time starts and ends with the surgical procedure. The Division finds that the electrophysiologic testing and monitoring started at "10:51:14" and ended at "11:22:20" for a total of 31 minutes. Based upon the AMA CPT guidelines for code 95920, the requestor has not supported billing the second hour of code 95920. As a result, reimbursement is not recommended.

2. The respondent denied reimbursement for CPT code 95925-TC based upon reason code "B291."

   Per 28 Texas Administrative Code §134.203(b)(1), the Division referred to the CCI edits to determine if the respondent's denial was appropriate. The Division finds that per CCI edits CPT code 95925 is not a component of any code billed on the disputed date of service; therefore, the respondent's denial is not supported.

   Furthermore, per the AMA CPT guideline, "Code 95920 is reported per hour of service, and includes only the ongoing electrophysiologic monitoring time distinct from performance of specific type(s) of baseline electrophysiologic study(s) (95860, 95861, 9585565, 95870, 95900, 95904, 95928, 95929, 95933-95937) or interpretation of specific type(s) of baseline electrophysiologic study(s) (92585, 95822, 95870, 95925-95928, 95929, 95930). The time spent performing or interpreting the baseline electrophysiologic study(s) should not be counted as intraopertive monitoring, but represents separately reportable procedures." Per AMA CPT guideline, code 95925 and 95926 are separately reportable procedures.

   The Division finds that the requestor is entitled to reimbursement for code 95925-TC.

3. The respondent denied reimbursement for CPT code 95926-TC based upon reason code "B291." Per CCI edits, CPT code 95926 is a component of code 95925 effective January 1, 2012. Because the disputed date of service is prior to this date, the rule is not applicable; therefore, the respondent's denial based upon reason code "B291" is not supported. The requestor is entitled to reimbursement for CPT code 95926-TC.

4. Based upon two and three above, the Division finds that the requestor is entitled to reimbursement for CPT codes 95925-TC and 95926-TC.

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) 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 $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2010 DWC conversion factor for this service is 54.32.

   The Medicare Conversion Factor is 36.8729

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 77401, which is located in Bellaire, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for "Houston, Texas".

Using the above formula, the Division finds the following:

Code	Medicare Participating Amount	Maximum Allowable Reimbursement	Carrier Paid	Due
95925-TC	$103.12	$151.91	$0.00	$151.91
95926-TC	$100.19	$147.59	$0.00	$147.59

5. The respondent denied reimbursement for HCPCS codes A4556 and A4557 based upon reason code "B291."

   HCPCS Code A4556 is defined as "Electrodes (e.g., apnea monitor), per pair", and A4557 is "Lead wires (e.g., apnea monitor), per pair."

   Per Medicare guideline, HCPCS codes A4556 and A4557 are status "P-Bundled/Excluded Codes." If HCPCS codes A4556 and A4557 are incidental to the physician service, they are not separately payable. A review of the submitted documentation does not support a separate service. As a result, reimbursement is not recommended.

6. CPT code 99080 is defined as "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form."

   The respondent's explanation of benefits notes "B327-Please provide explanation of CPT code 99080 for payment. Identify if report is for DWC069, DWC073, copy of records, or progress report. Attach a copy of this EOB with your resubmission."

   The requestor did not clarify if billing of CPT code 99080 was for a report or copy of records. A review of the billing did not include a modifier to indicate if it was a required Division report or service.

   In addition, per Medicare guidelines, code 99080 is a status "B-Bundled code." The requestor did not support a separate service that is reimbursable by the fee guidelines. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $299.50.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $299.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	12/19/2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

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