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
LISA PERSYN, MD

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number
M4-14-1459-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
JANUARY 27, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim was billed per Medical Fee Guideline conversion factors as established in 28 Texas Administrative Code 134.203."

Amount in Dispute: $617.08

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "For the CPT code 95886, Requestor billed for 2 units. This code, as described in the 2013 AMA CPT Professional Edition, states that this is a complete needle electromyography of each extremity in which five or more muscles were studied. The medical report shows that 6 muscles were studied during the EMG on the right side only. That equals one unit of CPT code 95886. Respondent correctly paid Requestor for one unit of CPT code 95886. Requestor also billed for the CPT code 95912. This code is described as 11-12 nerve conduction studies. Further definition states that each type of nerve conduction is counted only once when multiple sites on the same nerve are stimulated or recorded. The medical report shows that only 9 nerves were studied…Additionally, CPT code A4556, supplies for the EMG/NCV are not payable separately."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 2, 2013	CPT Code 99204 New Patient Office Visit	$0.00	$0.00
	CPT Code 95886 (X2) Needle EMG	$153.42	$0.00
	CPT Code 95912 Nerve Conduction Studies (11-12)	$438.66	$0.00
	HCPCS Code A4556 Electrodes	$25.00	$0.00
TOTAL		$617.08	$0.00

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:
   - W1-Workers compensation state fee schedule adjustment.
   - P300-The amount paid reflects a fee schedule reduction.
   - V182-Billed service lacks the required modifier. Appropriate modifier has been added or changed to reflect the documentation submitted.
   - V298-Documentation on the CMS1500 or UB04 is not supported by the information in the medical record.
   - B12-Services not documented in patients' medical records.
   - V163-Per CPT guidelines, supplies or materials normally required to complete the procedure or service should not be billed separately.
   - 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

Issues

1. Does the documentation support billing CPT code 95886 (X2)? Is the requestor entitled to additional reimbursement for CPT code 95886?
2. Does the documentation support billing CPT code 95912?
3. Is the benefit for HCPCS code A4556 included in the benefit of another service billed on the disputed date? Is the requestor entitled to reimbursement for HCPCS code A4556?

Findings

1. 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."

   The American Medical Association Current Procedural Terminology (CPT) defines code 95886 as "Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure)."

   A review of the submitted medical report finds "EMG of the right upper extremity was performed using an XLTEK Neuromax 1002 EMG machine and a sterile disposable monopolar needle." The documentation does not support the second EMG billed; therefore, reimbursement for the second EMG is not recommended.

   To determine if the requestor is due additional reimbursement for the documented CPT code 95886, the Division refers to 28 Texas Administrative Code §134.203(c)(1)(2), which states "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 2013 DWC conversion factor for this service is 55.3.

The Medicare Conversion Factor is 34.023

Review of Box 32 on the CMS-1500 the services were rendered in zip code 78230, which is located in San Antonio, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for "Rest of Texas".

The Medicare participating amount for code 95886 is $79.25

Using the above formula, the Division finds the MAR for code 95886 is $128.81. The respondent paid $128.82. As a result, reimbursement of $0.00 is recommended.

2. On the disputed date of service, the requestor also billed CPT code 95912 defined as 11-12 nerve conduction studies. A review of the submitted medical report supports 9 studies; therefore, the requestor did not support billing CPT code 95912. As a result, reimbursement is not recommended.

3. According to the explanation of benefits, the respondent denied reimbursement for HCPCS code A4556 based upon reason code "97."

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

   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."

   Per Medicare policy, if HCPCS codes A4556 is incidental to the physician service, it is not separately payable. A review of the submitted documentation does not support a separate service. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due for the specified services. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		12/04/2014
Signature	Medical Fee Dispute Resolution Officer	

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).

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