



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

MEMORIAL MRI AND DIAGNOSTIC

Respondent Name

INSURANCE CO OF THE STATE OF PA

MFDR Tracking Number

M4-15-1110-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

DECEMBER 11, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I received an explanation of benefits for date of service 03/05/2014. The bill was denied for a bill submission error. I corrected the claim and added the referring provider's license number to bill...Please reprocess this bill for reconsideration and remit payment according to the fee schedule."

Amount in Dispute: \$6,462.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOBs...the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 5, 2014	CPT Code 95912-59 Nerve Conduction Studies (11-12)	\$6,000.00	\$416.33
	CPT Code 95886 Needle EMG	\$386.00	\$144.05
	HCPCS Code A4215 Sterile Needle(s)	\$50.00	\$0.00
	HCPCS Code A4556 Electrodes	\$13.00	\$0.00
	HCPCS Code A4558 Conductive Gel	\$13.00	\$0.00
TOTAL		\$6,462.00	\$560.38

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, effective June 1, 2012 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
 - 193-Original payment decision is being maintained. Upon review , it was determined that this claim was processed properly.
 - 97-The benefit of this service is included in the payment allowance for another service/procedure that has already been adjudicated.
 - 112-Service is not furnished directly to the patient and/or not documented.

Issues

1. Does the documentation support billing CPT code 95912?
2. Does the documentation support billing CPT code 95886?
3. Is the requestor entitled to reimbursement for CPT codes 95886 and 95912?
4. Is the benefit for HCPCS codes A4215, A4556 and A4558 included in the benefit of another service billed on the disputed date?

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 95912-59 as "Nerve conduction studies; 11-12 studies."

The requestor appended modifier "59-Distinct Procedural Service" to code 95912.

A review of the submitted report supports 12 studies; therefore, the documentation supports billed service. The Division finds the requestor is due reimbursement per the Division fee guidelines.

2. CPT Code 95886 is defined 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 report supports EMGs; therefore, the documentation supports billed service. The Division finds the requestor is due reimbursement per the Division fee guidelines

3. 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 2014 DWC conversion factor for this service is 55.75.

The Medicare Conversion Factor is 35.8228

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77055, which is located in Houston, 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	Carrier Paid	Due
95912	\$267.52	\$416.33	\$0.00	\$416.33
95886	\$92.56	\$144.05	\$0.00	\$144.05

4. According to the explanation of benefits, the respondent denied reimbursement for HCPCS codes A4215, A4556 and A4558 based upon reason code "97."
- HCPCS code A4215 is defined as "Needle, sterile, any size, each."
 - HCPCS code A4556 is defined as "Electrodes (e.g., apnea monitor), per pair."
 - HCPCS code A4558 is defined as "Conductive gel or paste, for use with electrical device (e.g., TENS, NMES), per oz."

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, A4556 and A4558. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due for the specified services. As a result, the amount ordered is \$560.38.

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 \$560.38 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

04/07/2015

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.