



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

HARTFORD UNDERWRITERS INSURANCE

MFDR Tracking Number

M4-15-1113-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

DECEMBER 11, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to HARTFORD INSURANCE on September 30, 2014, this request was in response to a \$745.99 reduction of the \$1,360.12 for the EMG/NCV Designated Doctor Referred performed on February 27, 2014. Unfortunately our request was denied and we are seeking the balance owed to us."

Amount in Dispute: \$225.08

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment processed for additional (2) units of CPT 95886. Carrier upholds denial of CPT 95913 as amended/corrected billing submitted untimely per Rule 133.20."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 27, 2014	CPT Code 99203 New Patient Office Visit	\$0.00	\$0.00
	CPT Code 95886 (X4) Needle EMG	\$14.61	\$11.88
	CPT Code 95913 Nerve Conduction Studies (13 or more)	\$210.47	\$196.43
	HCPCS Code A4556 Electrodes	\$0.00	\$0.00
TOTAL		\$225.08	\$208.31

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:
 - 247-A payment or denial has already been recommended for this service.
 - B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.
 - 5359-We are unable to process your re-billing, as the documentation does not specify the concern regarding the original analysis. Please re-submit with a copy of the original EOR and a clarification for the basis of the reconsideration.
 - D1-Duplicate Control Number 203092738.
 - P12-Workers compensation jurisdictional fee schedule adjustment.
 - 309-The charge for this procedure exceeds the fee schedule allowance.
 - W3-Additional payment made on appeal/reconsideration.

Issues

Is the requestor entitled to additional reimbursement for CPT codes 95886 and 95913?

Findings

On March 31, 2015, the requestor's representative, Cindy, confirmed that an additional payment of \$288.10 was received for CPT code 95886, leaving a disputed amount of \$14.61 for this code.

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)."

CPT code 95913 is defined as "Nerve conduction studies; 13 or more studies."

Per 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 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 78752, which is located in Austin, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for "Austin, Texas".

Using the above formula, the Division finds the following:

Code	Medicare Participating Amount	Maximum Allowable	Carrier Paid	Due
95913	\$308.32	\$479.83	\$283.40	\$196.43
95886	\$92.56	\$144.05 X 4 = \$576.20	\$564.32	\$11.88

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 \$208.31.

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 \$208.31 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.