



# 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**

JAMES S. GARRISON, MD

**Respondent Name**

LM INSURANCE CORP

**MFDR Tracking Number**

M4-16-2785-01

**Carrier's Austin Representative**

Box Number 01

**MFDR Date Received**

MAY 11, 2016

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134."

**Amount in Dispute:** \$632.51

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Code 99204 was billed in combination with codes 95909 and 95886 which have 'XXX' and 'ZZZ' global days. Medicare indicates that E&M should not be billed with 'XXX' procedures since the procedure components include the pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. Codes with 'ZZZ' global days indicates the services are included in the global period of another related service. CPT Code 95909...Per the report, studies were completed on the right and left peroneal motor nerves and the right and left peroneal sensory nerves. Only four studies completed, which does not meet criteria for CPT code 95909. CPT Code 95886..is an 'add-on' code that requires a primary procedure. Code 95886 denied for primary procedure. HCPCS Code A4556, electrodes per pair, was denied as supplies are not separately payable per Medicare guidelines."

**Response Submitted By:** Liberty Mutual Insurance Co.

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 25, 2016	CPT Code 99204 New Patient Office Visit	\$255.66	\$0.00
	CPT Code 95886 Needle EMG	\$142.06	\$142.06
	CPT Code 95909 Nerve Conduction Studies (5-6)	\$218.19	\$0.00
	HCPCS Code A4556 Electrodes	\$25.00	\$0.00
TOTAL		\$632.51	\$142.06

## ***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, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced / denied by the respondent with the following reason code:
  - X263-The code billed does not meet the level/description of the procedure performed/documented. Consideration will be given with coding that reflects the documented procedure.
  - U058-Procedure code should not be billed without appropriate primary procedure.
  - M384-Supplies and materials included in the procedure.
  - 193-Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
  - W3-Additional payment made on appeal/reconsideration.

### **Issues**

1. Does the documentation support billing CPT code 99204?
2. Does the documentation support billing CPT code 95886?
3. Does the documentation support billing CPT code 95909?
4. 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. According to the explanation of benefits, the respondent denied reimbursement for CPT code 99204 based upon reason code X263".

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."

CPT code 99204 is defined as "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family."

The respondent contends that "Code 99204 was billed in combination with codes 95909 and 95886 which have 'XXX' and 'ZZZ' global days. Medicare indicates that E&M should not be billed with 'XXX' procedures since the procedure components include the pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. Codes with 'ZZZ' global days indicates the services are included in the global period of another related service."

The Division reviewed the submitted medical report and finds that the requestor has not supported billing a separate evaluation in conjunction with the nerve studies. As a result, reimbursement is not recommended

for CPT code 99204.

- 2. According to the explanation of benefits, the respondent denied reimbursement for CPT code 95886 based upon reason code "U058."

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 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 95886 is an add-on code, that describes additional work performed with the primary procedure. The primary procedure is the nerve conduction study (NCS). A review of the submitted medical bill finds that the requestor billed the needle EMG in conjunction with a NCS. The Division finds that the requestor's documentation supports billing CPT code 95886. As a result reimbursement is recommended.

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 2016 DWC conversion factor for this service 58.62

The Medicare Conversion Factor is 35.8043

Review of Box 32 on the CMS-1500 the services were rendered in zip code 76053, which is located in Fort Worth, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for "Fort Worth, Texas".

Using the above formula, the Division finds the following:

Code	Medicare Participating Amount	Maximum Allowable	Carrier Paid	Due
95886	\$91.90	\$150.46 or less	\$0.00	\$142.06

- 3. The respondent denied reimbursement for the nerve conduction studies based upon reason code "X263". CPT code 95909 is defined as a 5-6 nerve conduction studies. A review of the submitted medical report

supports 4 studies; therefore, the requestor did not support billing CPT code 95909. As a result, reimbursement is not recommended

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

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 A4556. 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 \$142.06.

***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 \$142.06 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

6/9/2016  
Date

***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, 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 MFDR 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.**