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
CLINIC OF NORTH TEXAS

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-17-2049-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
MARCH 6, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On the NCS, we billed 5-6 studies. Left median motor study, left ulnar motor study, left median sensory, left ulnar sensory and left APB."

Amount in Dispute: $444.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…the APB muscle is innervated by the median nerve. The documentation indicates motor units of the APB were tested. This would simply be motor testing of a different site on the left median motor. The 2016 CPT manual states in part 'Each type of nerve conduction study is counted only once when multiple sites on the same nerve are stimulated or recorded'."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 12, 2016	CPT Code 95909 Nerve Conduction Studies (5-6)	$288.00	$0.00
	CPT Code 95885 Needle EMG	$156.00	$0.00
TOTAL		$444.00	$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, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC16-Claim/service lacks information which is needed for adjudication.
   - CACP12-Workers' compensation jurisdictional fee schedule adjustment.
   - 225-The submitted documentation does not support the service being billed we will re-evaluate this upon receipt of clarifying information.
   - 714-Accurate coding is essential for reimbursement, CPT/HCPCS billed incorrectly. Corrections must be submitted w/I 95 days from DOS.
   - 725-Approved non-network provider for Texas Star network claimant per rule 1305.153(C).
   - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
   - CACW3, 350-In accordance with TDI-DWC 134.804, this bill has been identified as a request for reconsideration or appeal.
   - CAC193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Does the documentation support billing CPT code 95909? Is the requestor due reimbursement?
2. Is the requestor entitled to additional reimbursement for code 95885?

Findings

1. According to the submitted explanation of benefits, the respondent denied payment for CPT code 95909 based upon reason codes "CAC16-Claim/service lacks information which is needed for adjudication," "225-The submitted documentation does not support the service being billed we will re-evaluate this upon receipt of clarifying information," and "714-Accurate coding is essential for reimbursement, CPT/HCPCS billed incorrectly. Corrections must be submitted w/I 95 days from DOS."

   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 (AMA) Current Procedural Terminology (CPT) defines code 95909 as "Nerve conduction studies; 5-6 studies."

   The Division finds that the requestor's documentation supports left median motor and sensory, left ulnar motor and sensory studies, for a total of four. The requestor states "left APB." The left Abductor Pollicis Brevis (APB) is a muscle not a nerve; therefore, it does not count towards the total nerves tested. The Division concludes that the respondent's denial is supported. As a result, reimbursement is not recommended.

2. The respondent paid $88.25 for CPT code 95885 based upon reason code "CACP12-Workers' compensation jurisdictional fee schedule adjustment," and "790-This charge was reimbursed in accordance to the Texas medical fee guideline."

CPT code 95885 is defined as "Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure)."

To determine if additional reimbursement is due for CPT code 95885, 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 2016 DWC conversion factor for this service is 56.82.

The Medicare Conversion Factor is 35.8043.

Review of Box 32 on the CMS-1500 the services were rendered in zip code 76302, which is located in Wichita Falls, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for "Rest of Texas".

Using the above formula, the Division finds the following:

Code	Medicare Participating Amount	Maximum Allowable	Carrier Paid	Due
95885	$55.61	$88.25	$88.25	$0.00

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. 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

		03/29/2017
Signature	Medical Fee Dispute Resolution Officer	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.