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
NATHANIEL KHO, MD

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-19-4124-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
MAY 13, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim was billed correctly I have numbered on the report the amount of studies on the Nerve Conduction part with is more than 13 studies per AMA CPT 2019. The add on code is also correctly billed with the principle procedure per AMA CPT 2019."

Amount in Dispute: $3,445.19

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill was denied for inaccurate coding for cpt code 95913. Documentation submitted supports 12 payable studies. Motor waves are global to F waves (Median/Ulnar R/L). Each type of nerve conduction study is counted only once when multiple sites on the same nerve are stimulated of recorded per AMA CPT 2018, p. 668."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 30, 2019	CPT Code 95913 Nerve Conduction Studies	$2,136.89	$0.00
	CPT Code 95886 (X2) Needle EMG	$1,308.30	$0.00
TOTAL		$3,445.19	$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, effective May 31, 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 code:
   - CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
   - CAC-B15-This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.
   - 446-This add-on code has been denied as the principal procedure was not billed.
   - 714-Accurate coding is essential for reimbursement, CPT/HCPCS billed incorrectly. Corrections must be submitted w/I 95 days from DOS.
   - 891-No additional payment after reconsideration.
   - CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to reimbursement for professional services billed with CPT codes 95913 and 95886 on January 30, 2019?

Findings

1. The requestor is seeking dispute resolution in the amount of $3,445.19 for CPT codes 95913 and 95886 rendered on January 30, 2019.
2. The fee guidelines for disputed services is found in 28 Texas Administrative Code §134.203.
3. 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 disputed services are described by AMA CPT code book as:

   - CPT code 95913 - "Nerve conduction studies; 13 or more studies."
   - CPT code 95886 - "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)."
4. The respondent denied reimbursement for CPT code 95913 based upon "714-Accurate coding is essential for reimbursement, CPT/HCPCS billed incorrectly. Corrections must be submitted w/I 95 days from DOS."

   The respondent wrote, "Documentation submitted supports 12 payable studies. Motor waves are global to F waves (Median/Ulnar R/L)."

   The requestor contends that more than 13 studies were performed and payment is due. A review of the nerve conduction study report lists the number "18".

   The AMA, CPT coding guidelines provides coding guidelines for 95913:

   > For the purposes of coding, a single conduction study is defined as a sensory conduction test, a motor conduction test with or without an F wave test, or an H-reflex test. Each type of study (sensory, motor with or without F wave, H-reflex) for each nerve includes all orthodromic and antidromic impulses associated with that nerve and constitutes a distinct study when

determining the number of studies in each grouping (eg, 1-2 or 3-4 nerve conduction studies). Each type of nerve conduction study is counted only once when multiple sites on the same nerve are stimulated or recorded. The numbers of these separate tests should be added to determine which code to use.

5. The respondent denied reimbursement for CPT code 95886 based upon "CAC-B15-This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated," and "446-This add-on code has been denied as the principal procedure was not billed."

   Per *Chapter I General Correct Coding Policies for Correct Coding Initiative Policy Manual for Medicare Services*, (R) titled *Add-On Codes*:

   > Some codes in the *CPT Manual* are identified as "add-on" codes which describe a service that can only be reported in addition to a primary procedure…Add-on codes permit the reporting of significant supplemental services commonly performed in addition to the primary procedure…In general, NCCI procedure-to-procedure edits do not include edits with most add-on codes because edits related to the primary procedure(s) are adequate to prevent inappropriate payment for an add-on coded procedure. (I.e., if an edit prevents payment of the primary procedure code, the add-on code shall not be paid.)

   Per *Publication 100-04, Medicare Claims Processing, Transmittal 2636, Change Request 7501*, effective January 16, 2013:

   > An add-on code is a HCPCS/CPT code that describes a service that is always performed in conjunction with another primary service. An add-on code is eligible for payment only if it is reported with an appropriate primary procedure performed by the same practitioner…Add-on codes may be identified in three ways:
   >
   > (1) The code is listed in this CR or subsequent ones as a Type I, Type II, or Type III, add-on code.
   >
   > (2) On the Medicare Physician Fee Schedule Database an add-on code generally has a global surgery period of "ZZZ".
   >
   > (3) In the *CPT Manual* an add-on code is designated by the symbol "**+**". The code descriptor of an add-on code generally includes phrases such as "each additional" or "(List separately in addition to primary procedure)."
   >
   > CMS has divided the add-on codes into three Groups to distinguish the payment policy for each group.
   >
   > (1) Type I - A Type I add-on code has a limited number of identifiable primary procedure codes. The CR lists the Type I add-on codes with their acceptable primary procedure codes. A Type I add-on code, with one exception, is eligible for payment if one of the listed primary procedure codes is also eligible for payment to the same practitioner for the same patient on the same date of service. Claims processing contractors must adopt edits to assure that Type I add-on codes are never paid unless a listed primary procedure code is also paid. Pursuant to *Internet Only Manual, Claims Processing Manual*, Publication 100-04, Chapter 12, Section 30.6.12(I) described in the "Background" section of this CR, CPT code 99292 may be paid to a physician who does not report CPT code 99291 if another physician of the same specialty in his group practice is paid for CPT code 99291 on the same date of service.

   Per *Publication 100-04, Medicare Claims Processing, Transmittal 2636, Change Request 7501*, effective January 16, 2013, CPT code 95886 is classified as a Type I code. Therefore, the above referenced guidelines apply. Based upon this guideline, CPT code 95886 is not eligible for reimbursement because the primary procedure code 95913 is not eligible for reimbursement. 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.

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

______________________	______________________	06/27/2019
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.