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
NUEVA VIDA BEHAVIORAL HEALTH

Respondent Name
LIBERTY MUTUAL INSURANCE CO

MFDR Tracking Number
M4-20-1976-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
APRIL 14, 2020

REQUESTOR'S POSITION SUMMARY

"The Carrier denied payment for the above mentioned date of service for 'preauthorization was required.' 28 TAC 134.600(p) lists the non-emergency treatment/services that require preauthorization. Range of motion and muscle testing services is not listed as a procedure that requires preauthorization."

May 29, 2020: "Although the Carrier only paid a portion of the amount billed ($345.11), Dr. Gilbert Gonzales (treating physician) opines additional monies are owed for treatment rendered. An appeal letter was submitted to justify the request for additional payment."

Amount in Dispute: $2,280.00 less $343.11 = $1,936.89

RESPONDENT'S POSITION SUMMARY

"The bill has been reviewed and adjusted for payment – copies of EOBs will be submitted for your review once available."

Response Submitted By: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 4, 2019	CPT Code 95831 (X32) Muscle testing	$1,868.15	$0.00
	CPT Code 95832 (X2) Muscle testing of hand	$68.74	$0.00
	CPT Code 95861 (X4) Needle electromyography	$0.00	$0.00
TOTAL		$1,936.89	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2012 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
3. 28 TAC §134.600, effective November 1, 2018, requires preauthorization for specific treatments and services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 5917-Pre-authorization was required, but not requested for this service per DWC rule 134.600.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 309-The charge for this procedure exceeds the fee schedule.
   - 076-Fee schedule amount is equal to the charge.
   - 5833-Charge denied due to excessiveness or frequency of treatment.
   - W3-Additional payment made on appeal/reconsideration.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to additional reimbursement for muscle testing rendered on June 4, 2019?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $2,280.00 for CPT codes 95831, 95832, and 95861 rendered on June 4, 2019. The respondent originally denied payment for these codes based upon a lack of preauthorization. Upon receipt of the request for medical fee dispute resolution, the respondent did not maintain the denial and issued payment of $343.11. Only CPT codes 95831 and 95832 remain in dispute.
2. The fee guidelines for disputed services is found at 28 TAC §134.203.
3. 28 TAC §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."
4. The National Correct Coding Initiative Policy Manual for Medicare Services Chapter 1, (J), effective January 1, 2019, states,

   > If a CPT code descriptor includes the term "separate procedure", the CPT code may not be reported separately with a related procedure. CMS interprets this designation to prohibit the separate reporting of a "separate procedure" when performed with another procedure in an anatomically related region often through the same skin incision, orifice, or surgical approach.
   >
   > A CPT code with the "separate procedure" designation may be reported with another procedure if it is performed at a separate patient encounter on the same date of service or at the same patient encounter in an anatomically unrelated area often through a separate skin incision, orifice, or surgical approach. Modifier 59 or a more specific modifier (e.g., anatomic modifier) may be appended to the "separate procedure" CPT code to indicate that it qualifies as a separately reportable service.

   CPT code 95831 is described as "Muscle testing, manual (separate procedure) with report." The requestor billed for 32 units. Based upon the code descriptor it does not designate separate reimbursement for each

muscle tested at the same encounter on the same date of service. The requestor submitted one report; therefore, the number of units billed is not supported.

CPT code 95832 is described as "Muscle testing, manual (separate procedure) with report; hand, with or without comparison." The requestor billed for 2 units. Based upon the code descriptor it does not designate separate reimbursement for each muscle tested at the same encounter on the same date of service. The requestor submitted one report; therefore, the number of units billed is not supported.

Based upon National Correct Coding Initiative Policy Manual for Medicare Services Chapter 1, (J), the code descriptor, and submitted report the DWC finds the requestor is due reimbursement for one unit of CPT code 95831 and 95832.

5. Per 28 TAC §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 DWC had been using this MEI annual percentage adjustment: The 2006 DWC 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) DWC conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

The 2019 DWC Conversion Factor is 59.19

The 2019 Medicare Conversion Factor is 36.0391

Review of Box 32 on the CMS-1500 the services were rendered in San Antonio, Texas; therefore, the locality will be based on the rate for "Rest of Texas".

CPT Code 95831:

The Medicare Participating amount for CPT code 95831 at this locality is $31.57.

Using the above formula, the DWC finds the MAR is $51.85. The respondent paid $51.85. As a result, additional reimbursement is not recommended.

CPT Code 95832:

The Medicare Participating amount for CPT code 95832 at this locality is $31.21.

Using the above formula, the DWC finds the MAR is $51.26. The respondent paid $51.26. As a result, additional reimbursement is not recommended.

Conclusion

For the reasons stated above, the DWC 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 DWC has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		8/6/2020
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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **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.