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
DALLAS TESTING

Respondent Name
ARCH INDEMNITY INSURANCE CO

MFDR Tracking Number
M4-20-2664-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JULY 13, 2020

REQUESTOR'S POSITION SUMMARY

"The above date of service was not paid and has been returned due to reason: 'Service not furnished directly to the patient and/or not documented.' This is incorrect…**I have attached a copy of the report**."

Amount in Dispute: $164.80

RESPONDENT'S POSITION SUMMARY

"Clinical Validation reviewed the disputed denial and has stated the denial will be upheld."
Response Submitted By: Coventry

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 25, 2020	CPT Code 95886 Needle EMG	$164.80	$164.80
	CPT Code 95910 Nerve Conduction Studies	$0.00	$0.00
TOTAL		$164.80	$164.80

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 (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 the reimbursement guidelines for the disputed service.

3. The respondent reduced / denied reimbursement for the disputed services based upon the following claim adjustment reason codes:

   - P12-Workers compensation jurisdictional fee schedule adjustment.
   - 112-Service not furnished directly to the patient and/or not documented.
   - W3-Request for reconsideration.

Issues

Is the requestor entitled to reimbursement for the disputed services rendered on February 25, 2020?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $164.80 for CPT code 95886 rendered on February 25, 2020.
2. The respondent denied reimbursement for CPT code 95886 based upon reason codes "P12" and "112." (description listed above)
3. The fee guidelines for disputed services are found in 28 TAC §134.203.

   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. CPT code 95886 is described 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)."

   The National Correct Coding Initiative Policy Manual, effective January 1, 2020, Chapter I, General Correct Coding Policies, section (R) titled Add-On Codes states:

   > Some codes in the "CPT Manual" are identified as "add-on" codes (AOCs), which describe a service that can only be reported in addition to a primary procedure. "CPT Manual" instructions specify the primary procedure code(s) for most AOCs. For other AOCs, the primary procedure code(s) is (are) not specified**.** When the "CPT Manual" identifies specific primary codes, the AOCs shall not be reported as a supplemental service for other HCPCS/CPT codes not listed as a primary code. AOCs permit the reporting of significant supplemental services commonly performed in addition to the primary procedure.

   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.

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.

As stated above, the primary procedure CPT code 95910 was supported and reimbursement was made.

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 eligible for reimbursement.

A review of the submitted report finds the requestor supported billed procedure; therefore, reimbursement is recommended.

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 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 2020 DWC conversion factor for this service is 60.32.
   The Medicare Conversion Factor is 36.0896
   Review of Box 32 on the CMS-1500 the services were rendered in Fort Worth, Texas.
   The Medicare participating amount for code 95886 in Fort Worth, Texas is $98.60.
   Using the above formula, the MAR is $164.80. The respondent paid $0.00. The DWC finds the requestor is due $164.80.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $164.80.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $164.80, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		08/27/2020
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.