TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
DONALD M. MCPHAUL, MD

Respondent Name
SAFETY NATIONAL CASUALTY CORP

MFDR Tracking Number
M4-21-0589-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
NOVEMBER 30, 2020

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: $668.42

RESPONDENT'S POSITION SUMMARY

"Attached please find the amended EOR under CN# 1936913197. CPT 99203.59 has been processed for additional payment in the amount of $184.30. * Please note TDI/MFDR has previously upheld the denial for A4556 and A4215 as being inclusive when NCS are performed… **CPT 95912 03/17/2020**-Provider billed $453.56, the provider was paid zero. CPT 95912 is for 'NERVE CONDUCTION STUDIES 11-12 STUDIES.' By the providers own admission only '6-8 nerves were documented and studied' …The code 95912 is not supported in the treatment notes. **No further payment is due the provider**."

Response Submitted By: Coventry

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 17, 2020	CPT Code 99203-25 New Patient Office Visit	$183.25	$0.00
	CPT Code 95886 Needle EMG	$0.00	$0.00
	CPT Code 95912 Nerve Conduction Studies	$453.46	$453.46
	HCPCS Code A4556 Electrodes	$16.90	$0.00
	HCPCS Code A4215 Needles	$14.71	$0.00
TOTAL		$668.42	$453.46

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:

   - 150-Payment adjusted because the payer deems the information submitted does not support this level of service.
   - 112-Payment adjusted as not furnished directly to the patient and/or not documented.
   - 97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 45-Charge exceeds fee schedule/maximum allowable or contracted legislated fee arrangement.
   - Significant, separately identifiable E/M service rendered.
   - The charge for this procedure exceeds the fee schedule allowance.
   - CV-Documented procedure does not appear to match the code description of the CPT code billed.
   - 243-The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
   - 309-The charge for this procedure exceeds the fee schedule allowance.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.

Issues

Is the requestor entitled to additional reimbursement for the disputed services rendered on March 17, 2020?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $311.43 for CPT codes 99203-25, 95912, A4556 and A4215 rendered on March 17, 2020.
2. The respondent originally denied reimbursement CPT code 99203-25. Upon receipt of this request for medical fee dispute resolution, the respondent did not maintain the denial and issued payment of $184.30. The DWC finds code 99203-25 was paid in full and will not be considered further in this decision.
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 95912 is described as "Nerve conduction studies; 11-12 studies."

   The respondent denied reimbursement for CPT code 95912 based upon "CV-Documented procedure does not appear to match the code description of the CPT code billed."

   A review of the submitted report finds the requestor tested the radial, medial, and ulnar nerves bilaterally both sensory and motor for a total of 12 studies; therefore, the requestor supported billing CPT code 95912. The DWC finds reimbursement is due for CPT code 95912.

   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 Dallas, Texas.

The Medicare participating amount for code 95912 in Dallas , Texas is $271.59.

Using the above formula, the MAR is $453.93 or less. The requestor is seeking $453.46. The respondent paid $0.00. As a result, reimbursement of $453.46 is recommended.

5. HCPCS code A4556 is described as "Electrodes (e.g., apnea monitor), per pair."

   The respondent denied reimbursement based upon "243-The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed."

   Per Medicare physicians' fee schedule, HCPCS code A4556, is a status "P" code.

   Status "P" codes are defined as "Bundled/excluded codes. There are no RVUs and no payment amounts for these services. No separate payment is made for them under the fee schedule. If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician service). If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (for example, colostomy supplies) and is paid under the other payment provision of the Act."

   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.

6. HCPCS code A4215 is described as "Needle, sterile, any size, each."

   The respondent paid $0.29 for HCPCS code A4215 based upon "309-The charge for this procedure exceeds the fee schedule allowance."

   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 A4215 in conjunction with CPT codes 95886 and 95912. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $453.46.

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 $453.46, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		1/06/2021
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.