



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

RANIL NINALA, MD

Respondent Name

AMERICAN ZURICH INSURANCE CORP

MFDR Tracking Number

M4-21-1997-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

JULY 12, 2021

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: \$437.24

RESPONDENT'S POSITION SUMMARY

"CPT codes 95886 and 95909 were denied on the basis of preauthorization denial."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 30, 2020	CPT Code 99204-25 New Patient Office Visit	\$0.00	\$0.00
	CPT Code 95886 (X1) Needle EMG	\$169.57	\$169.57
	CPT Code 95909 Nerve Conduction Studies	\$252.96	\$252.96
	HCPCS Code A4556 Electrodes	\$0.00	\$0.00
	HCPCS Code A4215 Needles	\$14.71	\$0.00
TOTAL		\$437.24	\$422.53

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 February 22, 2021, sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.600, effective November 1, 2018, requires preauthorization for specific healthcare services.
3. 28 TAC §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
4. The services in dispute were reduced / denied by the respondent with the following reason code:
 - P12-Workers' compensation jurisdictional fee schedule adjustment.
 - 39-Services denied at the time authorization/pre-certification was requested.
 - W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

Is the requestor entitled to reimbursement for CPT codes 95886, 95909, and A4215 rendered on November 30, 2020?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of \$437.24 for CPT codes 95886, 95909, and A4215 rendered on November 30, 2020.
2. The respondent denied reimbursement for CPT codes 95886 and 95909 based upon a lack of preauthorization.

28 TAC §134.600(p) lists the non-emergency healthcare that requires preauthorization. A review of 28 TAC §134.600(p) does not list CPT codes 95886 and 95909; therefore, the respondent's denial is not supported.
3. The fee guidelines for disputed services is 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."

Per 28 Texas Administrative Code §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 Austin, Texas.

The Medicare participating amount for code 95886 in Austin, Texas is \$101.54.

Using the above formula, the MAR is \$169.71 or less. The requestor is seeking \$169.57. The respondent paid \$0.00. As a result, reimbursement of \$169.57 is recommended.

The Medicare participating amount for code 95909 in Austin, Texas is \$151.47.

Using the above formula, the MAR is \$253.17 or less. The requestor is seeking \$252.96. The respondent paid \$0.00. As a result, reimbursement of \$252.96 is recommended.

- 4. The requestor is seeking medical dispute resolution for \$14.71 for HCPCS code A4215.

The respondent paid \$0.29 for HCPCS code A4215 based upon the fee guideline.

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

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 95909. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement of \$422.53 is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$422.53 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

8/11/2021
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.