TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
JOHN HOPKINS, DC, PHD

Respondent Name
ACCIDENT FUND GENERAL INSURANCE CO.

MFDR Tracking Number
M4-24-0135-01

Carrier's Austin Representative
Box Number 06

DWC Date Received
September 14, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 2, 2023	95913 and 95886	$966.00	$473.98
	Total	$966.00	$473.98

Requestor's Position

"We do appreciate Attorney Stone trying to resolve this issue and offer 50% payment. It is also our position to try to resolve this case also. As we stated earlier, we had approval from insurance carrier initially to do the test and rule out (redacted) and any (redacted). This case due to the nature of injury and severity of injury was more than just a …stated by carrier… Our position is our initial fee was fair and reasonable to resolve this issue."

Amount in Dispute: $966.00

Respondent's Position

"After review of the dispute, Accident Fund submitted the bill for audit and issued payment of $481.33 in payment for the disputed date of service of 6/2/23. Please consider this in issuing your decision in regard to this dispute."

Response Submitted by: Stone Loughlin Swanson

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.305 sets out the procedures for resolving medical disputes.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 TAC §134.203 sets out the fee guideline for professional medical services.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- B15 – A primary procedure has not been billed and/or recommended for payment. A charge for an add-on procedure cannot be paid.
- B13 – The provider has billed for the exact services on a previous bill.
- P12 – The provider or a different provider has billed for the exact services on a previous bill where no allowance was originally recommended.
- B13 –Previously paid. Payment for this claim/service may have been provided in a previous payment.
- B15 – This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Did the insurance carrier issue a payment after the submission of the DWC060 request?
2. What rule applies to the reimbursement of the disputed service?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for CPT codes 95913 x 1 unit and 95886 x 4 units in the amount of $966.00, rendered on June 2, 2023. The insurance carrier issued a payment in the amount of $481.33, after the submission of the request for medical fee dispute resolution.

   The fee guidelines for the 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."

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).”

CPT code 95913 is described as, “nerve conduction studies; 13 or more studies.”

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.

The primary procedure code 95913 was supported and a partial payment was made by the insurance carrier.

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 documented and billed for the disputed procedures; therefore, reimbursement is recommended.

2. 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. The 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 2023 DWC conversion factor for this service is 64.83
- The 2023 Medicare Conversion Factor is 33.8872
- The dispute services were rendered in zip code 75240; "Dallas."

- The Medicare participating amount for code 95913 is $291.62.
- Using the above formula, the MAR is $557.90.

- The Medicare participating amount for code 95886 is $99.87.
- Using the above formula, the MAR is $191.06 x 4 units = MAR $764.25.

- The total recommended amount is $557.90 + 764.25 = $955.31
- The respondent paid $481.33.
- The DWC finds the requestor is due $473.98.

3. The DWC finds that due to the reasons indicated above, the requestor is entitled to an additional payment in the amount of $473.98. This amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The DWC finds the requester has established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, the DWC has determined the requestor is entitled to $473.98 reimbursement for the disputed services. It is ordered that the respondent must remit to the requestor the amount of $473.98, plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TC §134.120.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 5, 2024 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.