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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
LONESTAR NEURO DIAGNOSTICS AND REHAB

Respondent Name
TASB RISK MGMT FUND

MFDR Tracking Number
M4-12-2201-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
FEBRUARY 27, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "95900 is a separate billable service."

Amount in Dispute: $515.34

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "95900 is global to 95903; *the description for 95900 is Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-Wave*. The description for 95903 is the same as 95900 but **with F-Wave**, the 2 codes are the same procedure so there would not be separate reimbursement for 95900."

Response Submitted By: TASB Risk Management Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 3, 2011	CPT Code 95900-59 (X6) Nerve Conduction Study – Motor without F-wave, each nerve	$515.34	$0.00

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.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, *33 Texas Register 364*, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 97-Component code 95900 Comprehensive code 95903. CCI explanation More extensive procedure. These procedures are either basically the same, or performed on the same site but are qualified by an increased level of complexity, the less extensive procedure (component code) is included in the more extensive procedure (comprehensive code). Applies to all lines.
   - 97-Payment is included in the allowance for another service/procedure.
   - W3-Additional payment made on appeal/reconsideration. Motor-RT Radial. 1/11/12-After further review

allowing payment. Applies to both lines.

- 193-Original payment decision is being maintained. Upon review it was determined that this claim was processed properly. 1/11/12-In addition comparison studies are not reimbursed.

Issues

1. Is the value of CPT code 95900 included in the value of another procedure billed on the disputed date?
2. Is the requestor entitled to additional reimbursement?

Findings

1. According to the submitted explanation of benefits, the respondent denied reimbursement for CPT code 95900 based upon reason code "97."

   Per 28 Texas Administrative Code §134.203(b)(1) "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   On the disputed dates of service, the requestor billed CPT codes99204-25, 95900-59, 95903-59, 95904-59, 95861-51, A4556, A4215 and A4558.

   According to the CCI edits, CPT code 95900 is a component of 95903; however, a modifier is allowed to differentiate the service. The requestor appended modifier "59-Distinct Procedural Service" to code 95900.

   Modifier "59" is defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

   A review of the submitted reports finds that the requestor performed motor nerve conduction studies on the Median, Radial and Ulnar nerves bilaterally. The F-wave studies were performed on the Median and Ulnar nerves bilaterally. Therefore, the motor nerve conduction studies performed on the Median and Ulnar nerves were a component of the F-wave studies. The studies performed on the Radial nerves bilaterally were not components.

2. As stated above, the requestor supported position that CPT code 95900 was not a component of 95903 for testing performed on the Radial nerves; therefore, reimbursement for two nerve studies is recommended.

   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 2011 DWC conversion factor for this service is 54.54.

   Review of Box 32 on the CMS-1500 the services were rendered in McAllen, Texas; therefore, the Medicare

participating amount is based upon the locality of “Rest of Texas”.

The Medicare conversion factor is 33.9764.

Using the above formula, the Division finds the following:

Code	Medicare Participating Amount	MAR	Total Paid	Total Due
95900	$57.52	$92.33 X 2 = $184.66	$184.66	$0.00

Conclusion

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

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	06/26/2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.