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
JAMES L. CARLISLE, MD

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-15-2595-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
APRIL 16, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to Liberty Mutual on December 8, 2014, this request was in response to nonpayment of the $993.47 for the EMG/NCV Designated Doctor Referred Exam performed on June 27, 2014. Unfortunately our request was denied and we are seeking the balance owed to us."

Amount in Dispute: $993.47

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT 95886 billed @ 2 units, were denied as procedure code should not be billed without appropriate primary procedure…Codes 95985-95987 may be reported with 95907-95913 for nerve conduction studies. As the primary procedure is the nerve conduction study code and was not supported and thus denied, payment could not be made for the add-on codes 95886 X 2 units. With correction of the nerve conduction code to the documented procedure code of 95911, the EMG code X2 would have been paid as supported…CPT code 99204…was denied with level of service not supported by documentation, the third key component- Medical Decision making is not supported in the documented report. HCPCS A4556 was denied as bundled or non-covered procedure based on Medicare guidelines…the electrodes required to perform the emg/nerve conduction studies. Supplies required to perform a procedure are not separately payable per Medicare guidelines."

Response Submitted by: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 9, 2014	CPT Code 99204 New Patient Office Visit	$260.23	$0.00
	CPT Code 95886 (X2) Needle EMG	$290.14	$289.44
	CPT Code 95912 Nerve Conduction Studies (11-12)	$418.10	$0.00

	HCPCS Code A4556 Electrodes	$25.00	$0.00
TOTAL		$993.47	$289.44

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, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - X901-Docuemtnation does not support level of service billed.
   - U058-Procedure code should not be billed without appropriate primary procedure.
   - X268-Per CPT guidelines, nerve conduction studies are paid per nerve, not per site along the same nerve.
   - B291-This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed.

Issues

1. Does the documentation support billing CPT code 99204?
2. Does the documentation support billing CPT code 95912?
3. Does the documentation support billing CPT code? Is the requestor due l reimbursement for CPT code 95886?
4. Is the benefit for HCPCS code A4556 included in the benefit of another service billed on the disputed date? Is the requestor entitled to reimbursement for HCPCS code A4556?

Findings

1. According to the submitted explanation of benefits, the respondent denied payment for CPT code 99204 based upon reason code "X901."

   28 Texas Administrative Code §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."

   The American Medical Association (AMA) Current Procedural Terminology (CPT) defines code 99204 as "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family."

   The Division finds that the requestor's documentation did not support medical decision making of moderate complexity; therefore, the requestor did not support billing CPT code 99204. As a result, reimbursement is not recommended.

2. The respondent denied reimbursement for CPT code 95912 based upon reason code "X901."

CPT code 95912 is defined as "Nerve conduction studies; 11-12 studies." A review of the submitted nerve conduction studies report indicates that the requestor performed 10 studies; therefore, the requestor did not support billing CPT code 95912. As a result, reimbursement is not recommended.

3. The respondent denied reimbursement for CPT code 95886based upon reason code "U058."

   CPT code 95886 is defined 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 95886 is an add-on code, that describes additional work performed with the primary procedure. The primary procedure is the nerve conduction study (NCS) . A review of the submitted medical bill finds that the requestor billed the needle EMG in conjunction with a NCS. The Division finds that the requestor's documentation support billing CPT code 95886 (X2). As a result reimbursement is recommended.

   The Division refers to 28 Texas Administrative Code §134.203(c)(1)(2), which states "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 2014 DWC conversion factor for this service is 55.75.

   The Medicare Conversion Factor is 35.8228.

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 75247, which is located in Dallas, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for "Dallas, Texas".

   Using the above formula, the Division finds the following:

Code	Medicare Participating Amount	Maximum Allowable	Carrier Paid	Due
95886	$92.99	$144.72 X 2 = $289.44	$0.00	$289.44

4. According to the explanation of benefits, the respondent denied reimbursement for HCPCS code A4556 based upon reason code "B291".

   HCPCS Code A4556 is defined as "Electrodes (e.g., apnea monitor), per pair."

   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, additional reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $289.44.

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 $289.44 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		06/11/2015
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 Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division 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 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 §141.1(d).

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