



**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**

AHMED KHALIFA, MD

**Respondent Name**

ZURICH AMERICAN INSURANCE CO

**MFDR Tracking Number**

M4-18-3695-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

JUNE 1, 2018

**REQUESTOR'S POSITION SUMMARY**

**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:** \$568.75

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Carrier has previously responded to this dispute on June 22, 2018. As noted in the carrier's June 22, 2018 response, the carrier was reprocessing the provider's bill. We are attaching a copy of an EOR dated June 28, 2018. The recommended allowance on the EOR is \$268.99. Additionally, an interest check in the amount of \$12.67 was also issued. The provider should have received both checks by now. That payment covered CPT code 99204. However, CPT code 95886 which covers a needle EMG was denied. It is not payable unless it is billed with a base code. It the provider wants reimbursement for that CPT code, she should resubmit his bill with a base code."

**Response Submitted By:** Flahive, Ogden & Latson

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 6, 2017	CPT Code 99204 New Patient Office Visit	\$268.99	\$0.00
	CPT Code 95886 Needle EMG	\$299.76	\$0.00
TOTAL		\$568.75	\$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, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 219-Based on extent of injury.
  - 107-Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.
  - 292-This procedure code is only reimbursed when billed with the appropriate initial base code.
  - 5343-Please note this is the reconsideration for a prior review.

## Issues

1. What is the applicable fee guideline for professional services?
2. Does an extent of injury issue exist in this case?
3. Is the requestor entitled to additional reimbursement for CPT code 99204?
4. Is the respondent's denial of payment for code 95886 supported?

## Findings

1. The requestor is seeking medical fee dispute resolution for CPT codes 99204 and 95886 rendered on July 6, 2017. The fee guidelines for disputed services is found in 28 Texas Administrative Code §134.203.
2. The respondent initially denied reimbursement for CPT code 99204 and 95886 based upon reason "219-Based on extent of injury." Upon reconsideration, the respondent did not maintain this denial and issued payment of \$268.99 for the office visit. The division finds that an extent of injury does not exist in this dispute.
3. On the disputed date of service the requestor billed \$268.99 for CPT codes 99204. The respondent submitted an explanation of benefits that support payment of \$268.99 was issued on July 2, 2018 via electronic funds transfer number 66702053 for code 99204. The division finds the requestor is not due any additional reimbursement for code 99204.
4. The respondent denied reimbursement for CPT code 95886 based upon "107-Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim," and "292-This procedure code is only reimbursed when billed with the appropriate initial base code."

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."

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)."

The CMS Policy Manual, Add-On-Code Edits, Change Request 7501, identifies three types of "add-on-codes". In this manual, code 95886 is classified as a Type I "add-on code." The NCCI edits manual indicates, "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."

CPT code 95886 is classified as an “add-on code”. CPT code 95886 may only be reported with primary codes 95907 through 95913 for nerve conduction studies. In this case, the requestor billed 95886 without the primary code; therefore, the respondent’s denial of payment is supported.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due.

**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**

		08/20/2018
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.**