



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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

LISA BARRETT, MD

Respondent Name

NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number

M4-18-5198-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

AUGUST 27, 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: \$319.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The code 95886 is for a complete EMG study of 5 or more muscles per side. The provider billed 95886 X 2 but only documented 4 muscles studied per side. The code to best describe the documentation is 95885 X 2."

Response Submitted By: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 13, 2018	CPT Code 99202-59 New Patient Office Visit	\$0.00	\$0.00
	CPT Code 95886 (X2) Needle EMG	\$289.00	\$0.00
	CPT Code 95911 Nerve Conduction Studies	\$0.00	\$0.00
	HCPCS Code A4556 Electrodes	\$16.90	\$0.00
	HCPCS Code A4215 Needles	\$13.80	\$0.00
TOTAL		\$319.70	\$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 code:
 - 112-Service not furnished directly to the patient and/or not documented.
 - P12-Workers compensation jurisdictional fee schedule adjustment.
 - P5-Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.
 - W3-Request for reconsideration.
 - 234-This procedure is not paid separately.

Issues

1. What is the applicable fee guideline for professional services?
2. Is the requestor due reimbursement for CPT codes 95886?
3. Is the allowance of HCPCS code A4556 included in the allowance of another service performed on this date?
4. Is the requestor due additional reimbursement for HCPCS code A4215?

Findings

1. The fee guidelines for disputed services are found in 28 Texas Administrative Code §134.203.
2. 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."

According to the explanation of benefits, the respondent denied payment for CPT code 95886 based upon reason code "112-Service not furnished directly to the patient and/or not documented."

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)."

A review of the submitted report supports studies of the R and L Gluteus Med; R and L Rectus Fem; R and L Tibialis Ant; and R and L Gastroc Ln H; therefore, four muscles studies were performed bilaterally. The division finds the respondent's denial of payment is supported.

paid \$612.20. As a result, the requestor is not due additional reimbursement for code 95886.

3. The requestor is seeking medical dispute resolution for \$16.90 for HCPCS code A4556.

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

The respondent denied reimbursement based upon reason codes "234-This procedure is not paid separately."

Per Medicare physicians' fee schedule, code A4556, is a status "P" code.

Status "P" codes are defined as "Bundled/excluded codes. There are no RVUs and no payment amounts for these services. No separate payment is made for them under the fee schedule. If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident (an example is an elastic

bandage furnished by a physician incident to a physician service). If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (for example, colostomy supplies) and is paid under the other payment provision of the Act.”

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, reimbursement is not recommended.

4. The requestor is seeking medical dispute resolution for \$13.80 for HCPCS code A4215.

HCPCS code A4215 is defined as “Needle, sterile, any size, each.” The respondent paid \$1.20 based upon reason code “P5-Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.”

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 95911. As a result, reimbursement is not recommended.

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

_____	_____	11/20/2018
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.