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**
Old Republic Insurance Company

**MFDR Tracking Number**
M4-24-1298-01

**Carrier's Austin Representative**
Box Number 44

**DWC Date Received**
February 14, 2024

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| February 20, 2023 | 95913, and 95886 | $674.99 | $557.08 |
| | **Total** | $674.99 | $557.08 |

## Requestor's Position

"...we had preauthorization approved and provided the ser□ice in good faith according to ODG treatment Guides, but for almost 12 months, the Gallagher Bassett, they did all to delay payment over and over again intentionally."

**Amount in Dispute:** $674.99

**Supplemental Response:** "No payment yet... as soon as we get any good news, we will update you so we can close this case. will update."

## Respondent's Position

"we have escalated the bills in question for manual review to determine if additional monies are owed. Supplemental response will be provided once the bill auditing company has finalized their review. Attached is a copy of all bills received to date, and their corresponding EOB's and payment details."

**Response Submitted by:** Gallagher Bassett

# 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:

- 5721 – To avoid duplicate bill denial for all reconsideration adjustments/additional payment requests. Sbmit a copy of the EOR or clear notation…
- 90202, B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 247 – A payment or denial has already been recommended for this service.
- 5405 – This charge was reviewed through the clinical validation program.
- 90403 & 112 – Service not furnished directly to the patient and/or not documented.
- P12 – Workers' compensation jurisdictional fee schedule allowance.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 5346 – Documented procedure does not appear to match the code description of the CPT code billed.

Issues

1. Did the insurance carrier support the denial reasons noted on the EOBs?
2. Is the requestor entitled to reimbursement?

Findings

1. The dispute pertains to the non-payment of nerve conduction studies and electromyography rendered on February 20, 2023, billed under CPT codes 95913, and 95886. The requestor is seeking reimbursement in the amount of $674.99. A review of the denial reduction codes finds that the insurance carrier audited and denied the disputed services.

   A review of the respondent's position summary submitted by Gallagher Bassett, states in pertinent part, "we have escalated the bills in question for manual review to determine if additional monies are owed."

The insurance carrier denied the disputed services with denial reduction code "5346," described as "Documented procedure does not appear to match the code description of the CPT code billed."

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."

28 TAC §134.203(b)(1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) 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."

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.

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- nerve conduction studies; 13 or more studies;" was supported and eligible for payment.

Publication 100-04, Medicare Claims Processing, Transmittal 2636, Change Request 7501, effective January 16, 2013, finds that 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 medical bill finds that the requestor billed one unit of CPT code 95913, and two units of 95886. A review of the medical documentation finds that the requestor documented one unit of CPT code 95913 and two units of CPT code 95886; therefore, reimbursement is recommended.

2. The fee guidelines for disputed services is found at 28 TAC §134.203.

28 TAC §134.203(c)(1) states, "…To determine to MAR for professional services, system participants shall apply the Medicare payment policies with minimal modification…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 $53.68…"

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

- The 2023 DWC Conversion Factor is 64.83
- The 2023 Medicare Conversion Factor is 33.8872
- The disputed service was rendered in zip code 75240; the Medicare locality is "Dallas."

The Medicare Participating amount for CPT code 95913 in this locality is $291.62.

- Using the above formula, the DWC finds the MAR is $557.90.
- The insurance carrier paid $151.99
- The difference between the insurance carrier payment of $151.99 and the MAR amount, $557.90 is $405.91.
- The requestor seeks reimbursement in the amount of $418.81.
- The requestor is due the lesser amount, $405.91. This amount is recommended.

The Medicare Participating amount for CPT code 95886 at this locality is $99.87.

- Using the above formula, the DWC finds the MAR is $191.06 x 2 units = MAR $382.12.
- The insurance carrier paid $139.82.
- The difference between the insurance carrier payment of $139.82 and the MAR amount, $382.12 is $242.30.
- The requestor seeks reimbursement in the amount of $256.18.
- The requestor is due the lesser amount, $242.30. This amount is recommended.

The DWC finds that the insurance carrier issued a supplemental payment in the amount of $91.13 after the submission of the MFDR request. Reimbursement is recommended in the amount of $648.21 minus the supplemental payment of $91.13 for a total recommended amount of $557.08. 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 requestor has established that reimbursement is due.

## Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the respondent must remit to the requestor $557.08 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

**Authorized Signature**

| | | |
|---|---|---|
| | | May 24, 2024 |
| 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 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, 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.