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
Liberty Insurance Corporation

MFDR Tracking Number
M4-25-0311-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
October 5, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 14, 2024	95913 x 1 unit	$584.00	$582.71
June 14, 2024	95886 x 2 units	$396.00	$196.62
	Total	$980.00	$779.33

Requestor's Position

"… we had pre-authorization approved and provided the service in good faith according to ODG treatment Guides, they are delaying to pay according to the fee schedule. They did all to delay payment repeatedly intentionally. The Liberty Mutual is using offshore company in Philippines… deny intentionally every case in bad faith, when we send for reconsideration… the same people deny payment over and over."

Amount in Dispute: $980.00

Respondents' Position

"The service provided on 6/14/24 had utilization management authorization which is attached above. That authorization stated 'Recommend prospective request for 1 EMG/NCV for the upper extremity between 6/4/2024 and 10/2/2024 be certified.' This is singular language showing that one EMG/NCV is authorized. The primary care physician recommended an EMG/NCV right upper extremity at the visit on 5/24/24, Please see the attached record above. The visit was for the… which were compensable body parts. The authorized service was for a right EMG/NCV… Due to system limitations, only one denial message can be used and that was that the documentation received (UM authorization) does not support the level of service billed since the provider counted for both the right and left sides for CPT 95913. There were not 13 or more nerves tested on the right upper extremity. The other code on the bill, 95886 x 2, was denied as there is no paid primary code on the bill."

Response Submitted by: Liberty Mutual Insurance

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 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the reimbursement guidelines for professional services.

Denial Reasons

The insurance carrier reduced or denied payment for the disputed services with the following claim adjustment codes:

- 589-The documentation received does not support the level of service billed. Please adjust the level of service billed or provide additional documentation to support the service billed.
- 292-This procedure code is only reimbursed when billed with the appropriate initial base code.

Issues

1. What are the services in dispute?
2. Are the Insurance carrier's denial reasons supported?
3. Is the requestor entitled to reimbursement for CPT code 95913 and 95886?

Findings

1. The requestor seeks reimbursement for CPT codes 95913 and 95886 provided to the injured employee on June 14, 2024.

   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: 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 date of service, the requester billed CPT codes 95913, and 95886.
   - CPT code 95913 is defined as "Nerve conduction studies; 13 or more studies."
   - 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)."

2. According to the explanation of benefits, the respondent denied reimbursement for CPT code 95913 based upon reason code "589 – The documentation received does not support the level of service billed. Please adjust the level of service billed or provide additional documentation to support the service billed."

   CPT code 95913 is described as 13 or more studies. A review of the submitted documentation finds that the Genex a URA authorized 1 EMG/NCV for the upper extremity. The medical documentation finds that provided conducted an NCV of the upper extremity. The division finds that the reason for denial is not supported. The requester is therefore entitled to reimbursement for CPT code 95913.

   The respondent denied reimbursement for CPT code 95886 based upon reason codes "292-This procedure code is only reimbursed when billed with the appropriate initial base code."

   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."

   CPT code 95886 is considered a complete study and is an add-on code that describes additional services associated with the primary procedure. This code is only paid when the appropriate base code is paid. The requestor billed with CPT code 95913 in conjunction with 95886. Per CMS guidelines, EMG studies, when performed with a nerve conduction study on the same day, should be billed using CPT codes 95885-95887. The division finds that the requester documented one unit of CPT code 95886, as a result reimbursement is recommended for one unit.

3. 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).

   - Date of the service in dispute: June 14, 2024
   - The 2024 DWC Conversion Factor is 67.81
   - The 2024B Medicare Conversion Factor is 33.2875
   - A review of the medical bills finds that the disputed services were rendered in zip code 75240; the Medicare locality is "Dallas."

   - The Medicare Participating amount for CPT code 95886 at this locality is $286.05.
   - Using the above formula, the DWC finds the MAR is $582.71.
   - The requestor seeks $584.00.
   - The respondent paid $0.00.
   - Reimbursement of $582.71 is recommended.

   - The Medicare Participating amount for CPT code 95886 at this locality is $96.52.
   - Using the above formula, the DWC finds the MAR is $196.62.
   - The requestor seeks $396.00.
   - The respondent paid $0.00.
   - Reimbursement of $196.62 is recommended.

The division concludes that the requestor is entitled to $779.33, therefore, this amount is due.

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.

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 $779.33 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 13, 2025 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, please call CompConnection at 1-800-252-7031, option three 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 tres o correo electronico CompConnection@tdi.texas.gov.