TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Principle Diagnostics, LLC

Respondent Name
Great West Casualty Co.

MFDR Tracking Number
M4-25-1714-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 7, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 15, 2024	95886-RT	$225.00	$197.34
February 15, 2024	95886-LT	$225.00	$197.34
February 15, 2024	95887-RT	$200.00	$170.02
February 15, 2024	95887-LT	$200.00	$0.00
February 15, 2024	95913	$1,700.00	$587.89
February 15, 2024	95937	$620.00	$427.56
February 15, 2024	Routine supplies	$180.00	$0.00
	Total	$3,350.00	$1,580.15

Requestor's Position

"We received a denial for this claim with no reason listed. EOB attached. We reached out to Reny company and were informed they could not help us with a reason or appeal it was a denial directly from adjuster they had no notes. Since this happened, we have spent months calling and emailing the adjuster for clarification with no response."
Amount in Dispute: $3,350.00

Respondent's Position

The Austin carrier representative for Great West Casualty Co. is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on April 9, 2025. Per 28 Texas Administrative Code §133.307 (d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information. As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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 fee guideline for professional medical services.

Adjustment Reasons

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

- P12 - Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Is the insurance carrier's denial reason supported?
2. Were the services in dispute preauthorized?
3. Is the requester entitled to reimbursement for CPT code 95913?
4. Is the requester entitled to reimbursement for CPT codes 95886 and 95887?
5. Is the requestor entitled to reimbursement for CPT code 95937?
6. Is the requestor entitled to reimbursement for supplies billed on the disputed date of service?
7. What is the total amount of reimbursement the requestor is entitled to for the disputed services rendered on February 15, 2024?

Findings

1. This medical fee dispute involves an electromyography and nerve conduction study referred by a treating doctor, rendered to an injured employee on February 15, 2024. A review of the submitted explanation of benefits (EOB) document dated March 29, 2024, finds the only reason provided for denial of reimbursement for the disputed services is "P12 – Workers' compensation jurisdictional fee schedule adjustment." DWC finds the respondent did not submit documentation to support this denial reason; therefore, the respondent's denial based upon P12 is not supported.

   DWC finds that the insurance carrier's reason for denial is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. A review of the submitted documentation finds a Certification Notification Letter dated February 2, 2024. The certification letter documents a request and preauthorization of CPT codes 95886 x 2 units, 95887 x 1 unit, 95913 x 1 unit, and 95937 x 4 units.

DWC finds that for services rendered on the disputed date of service, the following CPT codes and units were preauthorized by utilization review: 95886 x 2 units, 95887 x 1 unit, 95913 x 1 unit, and 95937 x 4 units.

3. The requestor is seeking reimbursement in the amount of $1,700.00 for one unit of procedure code 95913 rendered on February 15, 2024. Procedure code 95913 is described as "Nerve conduction studies; 13 or more studies." Per CMS article A54992 Billing and Coding: Nerve Conduction Studies and Electromyography, a single nerve conduction test is defined as a sensory conduction test, a motor conduction test (with or without an F wave test), or an H-reflex test. Each type of study (sensory, motor with or without F wave, H-reflex) for each anatomically distinct and separately named nerve is counted as a distinct study when determining the number of studies billed.

   A review of the medical record submitted supports that procedure code 95913 was rendered as defined above on the disputed date of service. Because the medical documentation submitted supports the service as billed, and because the insurance carrier's reason for denial is not supported, DWC finds that the requestor is entitled to reimbursement in accordance with the applicable rules and fee schedule.

   DWC finds that 28 TAC §134.203, which sets out the fee guideline for professional medical services, applies to the reimbursement of procedure code 95913. 28 TAC §134.203(c) states in pertinent part, "To determine the maximum allowable reimbursement (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."

   - MPPR rates are published by carrier and locality.
   - Per the submitted medical bills, the services were rendered in zip code 77007; Medicare locality is 18, Houston, TX.
   - To determine the MAR the following formula is used:
     (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = MAR
   - The 2024 DWC Conversion Factor is 67.81
   - The 2024 Medicare Conversion Factor on the date in dispute is 32.7442

   - The Medicare participating amount for CPT code 95913 on the disputed date of service at this locality is $283.88.
   - Using the above formula, DWC finds the MAR is $587.89 for CPT code 95913 in locality 18 on the disputed date of service.
   - The insurance carrier paid $0.00.
   - Reimbursement of $587.89 is recommended for CPT code 95913 rendered on February

15, 2024, in locality 18.

DWC finds that the requestor is entitled to reimbursement in the amount of $587.89 for procedure code 95913 rendered on the disputed date of service.

4. On the disputed date of service, the requestor billed the amount of $225.00 each, for procedure codes 95886-RT and 95886-LT. On the same date and the same medical bill, the requestor billed the amount of $200.00 each, for procedure codes 95887-RT and 95887-LT. The requestor is seeking the billed amounts for these codes.

   Procedure 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 the code for primary procedure)." The requestor appended the codes with RT and LT indicating one procedure performed on each right and left sides of the body.

   Procedure code 95887 is described as "Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study; (list separately in addition to the code for primary procedure)." The requestor appended the CPT codes with RT and LT indicating both procedures were performed on the right and left sides of the body.

   Procedure codes 95886 and 95887 are to be used when NCV (Nerve Conduction Velocity) testing and EMG are performed together on the same date of service on the same patient. In this case, the primary procedure code billed is 95913, reviewed and adjudicated in finding number two above.

   A review of the medical record submitted supports that procedure code 95886 was performed as defined above and as preauthorized, on both the right and left sides of the body, on the disputed date of service.

   A review of the submitted medical record supports that procedure code 95887 was performed as defined above on the disputed date of service. As discussed in finding number two above, CPT code 95887 was preauthorized for 1 unit of service. Therefore, this CPT code will be reviewed and adjudicated for one unit.

   Because the medical documentation submitted supports that the services in dispute were rendered, and because the insurance carrier's reason for denial is not supported, DWC finds that the requestor is entitled to reimbursement for CPT codes 95886-RT, 95886-LT, and 95887 x 1 unit, in accordance with the applicable rules and fee schedule.

   DWC finds that 28 TAC §134.203, as described in the previous finding, applies to the reimbursement of procedure code 95886 and 95887.

   - Per the submitted medical bills, the services were rendered in zip code 77007; Medicare locality is 18, Houston, TX.
   - To determine the MAR the following formula is used:

(DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = MAR

- The 2024 DWC Conversion Factor is 67.81
- The 2024 Medicare Conversion Factor on the date in dispute is 32.7442

For Procedure code 95886

- The requester billed 95886-RT x 1 unit and 95886-LT x 1 unit.
- The Medicare participating amount for CPT code 95886 on the disputed date of service at this locality is $95.29.
- Using the above formula, DWC finds the MAR is $197.34 for CPT code 95886 in locality 18 on the disputed date of service.
- The insurance carrier paid $0.00.
- Reimbursement of $197.34 is recommended for CPT code 95886-RT and in the amount of $197.34 for CPT code 95886-LT, rendered on February 15, 2024, in locality 18.

DWC finds that the requestor is entitled to a total reimbursement amount of $394.68 for procedure codes 95886-RT and 95886-LT, rendered on the disputed date of service.

For Procedure code 95887

- The requester billed 95887-RT x 1 unit and 95887-LT x 1 unit. This code was preauthorized for 1 unit. The following calculation will adjudicate MAR for 1 unit of CPT code 95887.
- The Medicare participating amount for CPT code 95887 on the disputed date of service at this locality is $82.10.
- Using the above formula, DWC finds the MAR is $170.02 for CPT code 95887 in locality 18 on the disputed date of service.
- The insurance carrier paid $0.00.
- Reimbursement in the amount of $170.02 is recommended for CPT code 95887 x 1 unit rendered on February 15, 2024, in locality 18.

DWC finds that the requester is entitled to reimbursement in the amount of $170.02 for procedure code 95887 x 1 unit, rendered on the disputed date of service.

5. The requestor is seeking reimbursement in the amount of $620.00 for 4 units of procedure code 95937. Procedure code 95937 is described as "Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method. Per CMS article A54992 Billing and Coding: Nerve Conduction Studies and Electromyography, this test consists of recording muscle responses to a series of nerve stimuli (at variable rates), both before, and at various intervals after, exercise or transmission of high-frequency stimuli. These codes may be used in association with motor and sensory NCS of the same nerves and are reimbursed separately.

   A review of the medical record submitted supports that 2 units of procedure code 95937 were rendered as defined above on the disputed date of service. Because the medical documentation submitted supports 2 units of 95937 and because the insurance carrier's reason for denial is not supported, DWC finds that the requestor is entitled to reimbursement for 2 units of 95937 in accordance with the applicable rules and fee schedule.

DWC finds that 28 TAC §134.203, as described in finding number two above, applies to the reimbursement of procedure code 95937.

- Per the submitted medical bills, the services were rendered in zip code 77007; Medicare locality is 18, Houston, TX.
- To determine the MAR the following formula is used:
  (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = MAR
- The 2024 DWC Conversion Factor is 67.81
- The 2024 Medicare Conversion Factor on the date in dispute is 32.7442
- The submitted documentation supports 2 units of 95937.
- The Medicare participating amount for CPT code 95937 on the disputed date of service at this locality is $103.23.
- Using the above formula, the MAR is $213.78 x 2 units for a total of $427.56 for CPT code 95937 in locality 18 on the disputed date of service.
- The insurance carrier paid $0.00.
- Reimbursement in the amount of $427.56 is recommended for 2 units of CPT code 95937 rendered on February 15, 2024, in locality 18.

6. The requester is seeking reimbursement in the amount $180.00 for various medical supplies.

   Per 28 TAC §134.203, Texas Workers' Compensation system participants are required to apply the Medicare payment policies for the billing and reimbursement of professional medical services. For the supply codes listed on the medical bill, DWC finds the following applies per Medicare payment policies and the Medicare Physician Fee Schedule:

   - HCPCS code A4554 has a status of "N" making it a non-covered service.
   - HCPCS code A4556 and A4558 have a status of "P"; status "P" codes are "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."
   - HCPCS code A4215 is defined as "Needle, sterile, any size, each" and has a status of "X", indicating statutory exclusion. Per Medicare guidelines, 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 medical record does not support a separate service for the billing of HCPCS code A4215 in conjunction with CPT codes 95886, 95887 and 95913.
   - HCPCS code A4245 is described as "Alcohol wipes per box" and has a status of "X", indicating statutory exclusion. Per Medicare guidelines, 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 medical record does not support a separate service for the billing of HCPCS code A4215 in conjunction with CPT codes 95886, 95887 and 95913.
   - HCPCS code A4927 is described as "non-sterile gloves" and has a status of "X", indicating statutory exclusion. Per Medicare guidelines, 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 medical record

does not support a separate service for the billing of HCPCS code A4215 in conjunction with CPT codes 95886, 95887 and 95913.

DWC finds that the requestor is not entitled to separate reimbursement for the medical supplies billed under the HCPCS codes listed above.

7. The requestor is seeking reimbursement in the total amount of $3,350.00 for electrodiagnostic services rendered on February 15, 2024. In accordance with 28 TAC §134.203, DWC has calculated the total MAR for this disputed date of service to be $1,580.15. This amount of reimbursement is recommended.

   DWC finds that the requestor is entitled to reimbursement in the total amount of $1,580.15 for the disputed services rendered on February 15, 2024.

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 in the amount of $1,580.15 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, Great West Casualty Co., must remit to the Requestor, Principle Diagnostics, LLC, $1,580.15 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	June 4, 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, 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.