TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
John Hopkins, DC, PhD

Respondent Name
Federal Insurance Company

MFDR Tracking Number
M4-26-0073-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
September 8, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 16, 2024	95913	$600.00	$0.00
September 16, 2024	95886	$400.00	$0.00
	Total	$1,000.00	$0.00

Requester's Position

"...even we had pre-authorization approved and provided the service in good faith according to ODG treatment Guides, they are delaying paying according to the fee schedule. They did all to delay payment repeatedly intentionally, deny intentionally every case in bad faith, when we send for reconsideration, they say, sure we will fix it then weeks later the same people deny payment over and over."

Amount in Dispute: $1,000.00

Respondent's Position

"The Carrier received the original billing for DOS 9/16/2024 on 11/11/2024. The HCP originally billed CPT codes 95913 (Nerve Conduction Studies 13/>) and 95886 (Needle EMG Each Extremity). Both lines were denied (as can be seen in the attached EOR (3303034-1,44). Corvel's Professional Review Nurse team determined that the documentation did not support 13 or more NCS tests. The F-waves wouldn't be counted in this particular bill since they were counted once already (under the Motor Nerve Conduction Studies). Per CPT 95911 is "with or without F wave". Total count for Motor Nerve Conduction tests + Sensory Nerve Conduction + H Flex tests is 10. Making 95911 the appropriate code."

Response Submitted by: CorVel

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 established procedures for resolving medical disputes.
2. 28 TAC §133.307 specifies the process for resolving medical fee disputes.
3. 28 TAC §134.203 provides the fee guidelines for professional medical services.
4. Texas Labor Code §401.011 defines key terms used in the Texas Workers' Compensation Act.
5. 28 TAC §141.1 provides the framework for dispute resolution and benefit review conferences.

Denial Reasons

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

- 16 – Svc lacks info needed or has billing error(s)
- Note: Documentation does not support 13 or more studies. Therefore, there is a more appropriate CPT supported.
- Note: Add on codes cannot be considered without consideration of primary CPT.
- B12 – Svcs not documented in patient medical records.

Issues

1. What are the services in dispute?
2. What are the denial reasons raised during the medical bill review process?
3. Are the Insurance carrier's denial reasons supported?
4. Is the requestor entitled to reimbursement?

Findings

1. This medical fee dispute involves Dr. John Hopkins and the Federal Insurance Corporation, concerning services rendered on September 16, 2024. The specific services in dispute include the following CPT codes:
    - CPT 95913 – *Nerve Conduction Studies, 13 or more studies* – billed at $584.00
    - CPT 95886 – *Needle EMG, each extremity with related paraspinal areas (add-on code)* – billed at $396.00
    - Total disputed amount: $1,000.00
    - Total billed amount on medical bill: $980.00
    - Dr. Hopkins asserts that the services were rendered in good faith, preauthorized, and consistent with ODG treatment guidelines.

2. According to the Explanation of Benefits (EOB), the insurance carrier denied reimbursement for CPT 95913 based on the following reason codes:
    - 16 – Service lacks information or contains billing errors
    - B12 – Services not documented in the patient's medical records
    - Additional Note: "Documentation does not support 13 or more studies. A more appropriate CPT code should have been billed."

    And denied CPT Code 95886 based on the following reason codes:
    - 16 – Svc lacks info needed or has billing error(s)
    - Note: Add on codes cannot be considered without consideration of primary CPT.

    The carrier indicates that the documentation supports fewer than 13 studies, which would correspond to CPT 95911, not 95913. CPT code 95886 is an add-on code and is not payable if the primary code(s) are not paid. As such, the insurance carrier contends that the provider is entitled to $0.00 reimbursement.

3. 28 TAC §134.203(a)(5) applies to the disputed services and references Medicare payment policies, including coding, billing, and documentation requirements set forth by CMS.

    CPT 95913 (Nerve Conduction Studies, 13 or more studies):
    According to the CMS Medicare Claims Processing Manual, Chapter 13, Section 20.9.1:

    - The number of nerve conduction studies must be clearly documented to justify the CPT code billed.
    - F-waves are considered part of motor nerve conduction studies and are not counted separately when determining the number of studies.

    A review of the submitted documentation finds:

    - The total number of documented studies (Motor NCS + Sensory NCS + H-reflex) equals 10 studies, which do not meet the documentation requirements for CPT 95913 (which requires 13 or more).
    - Therefore, the use of CPT 95913 is not supported by the documentation.

The DWC finds that the insurance carrier's denial of CPT 95913 is supported, and reimbursement is not recommended.

CPT 95886 (Needle EMG Each Extremity):
This is an add-on code for needle EMG performed on each extremity, with or without related paraspinal areas. It must be billed alongside a primary EMG code, and the documentation must clearly indicate the extremities tested.

Per CMS Publication 100-04, Transmittal 2636, and the National Correct Coding Initiative (NCCI) Policy Manual, CPT 95886 is classified as a Type I Add-On Code, which:

- Must be reported in conjunction with an approved primary procedure.
- It is not reimbursable unless billed alongside an eligible primary EMG code, performed by the same provider on the same date of service.

A review of the medical documentation finds that it does not support the level of service billed under CPT code 95913. Since CPT 95913 is not substantiated by the documentation, the add-on code CPT 95886 is not eligible for separate reimbursement. Therefore, the insurer's denial of CPT 95886 is supported and consistent with the documentation review.

4. Based on the reasons stated above, the DWC concludes that the requester has not demonstrated entitlement to reimbursement for the disputed services. Consequently, a reimbursement amount of $0.00 is recommended.

Conclusion

The resolution of this medical fee dispute is determined by the evidence provided by both the requester and the respondent during the adjudication process. While not all evidence may have been thoroughly discussed, all relevant information was considered in reaching a decision.

The DWC finds the requester has not established that reimbursement is due.

Order

Under Texas Labor Code §§ 413.031 and 413.019, the Division of Workers' Compensation (DWC) has determined that the requester is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		November 21, 2025
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, 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 512-804-4812.