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

Requester Name

Physiotherapy of El Paso

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-26-2433-01

Insurance Carrier's Austin Representative

BOX 54 Texas Mutual Insurance Co

DWC Date Received

April 29, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
May 20, 2025	95912	$601.00	$0.00
May 20, 2025	95886	$189.00	$189.00
	Total	$790.00	$189.00

Requester's Position

"Please take time to review the medical records for the above-named patient. This claim was denied by the carrier on two separate occasions. Our billing company was not submitting the corrected report/medical documentation for the diagnostic study patient had done on 05/20/2025."

Amount In Dispute: $790.00

Respondent's Position

"On 01/27/2026, Texas Mutual received the attached bill appeal, however, the health care provider did not submit any new documentation or information to support the services being billed and our initial denial was upheld. Our position is that no payment is due."

Response Submitted By: Texas Mutual

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code Section 413.031 and other applicable laws and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) Section 133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC Section 134.203 sets out the fee guidelines for professional medical services.

Adjustment Reasons

The insurance carrier denied payment for the disputed services with the following reasons:

- CAC-P12 – Workers compensation jurisdictional fee schedule adjustment.
- CAC-16 – Claim/service lacks information or has submission/billing errors(s) which is needed for adjudication.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 892 – Denied in accordance with DWC Rules and/or medical fee guideline including current CPT code descriptions/instructions.
- CAC-W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 891 – No additional payment after reconsideration.

Issues

1. What is DWC considering in this medical fee dispute?

2. Is the denial for lack of supporting documentation supported?

3. What rule is applicable to fee guideline?

4. Has DWC determined whether reimbursement is due?

Findings

1. The requester is seeking reimbursement of code 95912 – Nerve Conduction Text 11-12 and 95886 – Muscle test in the amount of $790.00 for date of service May 20, 2025. The insurance carrier denied the services as documentation does not support the billed codes. DWC will review the applicable reimbursement guidelines applicable to these professional medical services.

2. The applicable reimbursement guideline for professional medical services is found in 28 TAC Section 134.203(b)(1) which 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.

   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.

   The applicable Medicare payment policy for Nerve Conduction Studies 11-12 studies (**95912**) is found at Billing and Coding; Nerve Conduction Studies and Electromyography (A57478), https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=57478&ver=40& and states, Codes 95907-95913 describe 1 or more nerve conduction studies. A single 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 nerve is counted as a distinct study when determining the number of studies billed.
   Each type of study is counted only once when multiple sites on the same nerve are stimulated and recorded. The number of tests (sensory, motor with or without F wave, H reflex) per nerve should be added to determine the code to be billed.

   Review of the submitted Nerve Conduction Studies Motor Summary Table does not support the submitted number of tests. The insurance carrier's denial is supported.

   The applicable Medicare payment policy for code **95886** – 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 is also found at the above web site and

states, To bill these codes, extremity muscles innervated by 3 nerves (for example, radial, ulnar, median, tibial, peroneal, femoral, not sub branches) or four spinal levels must be evaluated; a **minimum of 5 muscles must have been studied**. Review of the EMG portion of the report supports that the minimum of 5 muscles were studied. The insurance carrier's denial is not supported.

The requester is entitled to reimbursement of code 95886. The fee guideline calculation is shown below.

3. DWC Rule 28 TAC Section 134.203 states in pertinent part, (c) 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…

   (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…"

   The following formula represents the calculation of the DWC MAR at Section 134.203 (c)(1) &(2). (DWC Conversion Factor ÷ Medicare Conversion Factor) x Medicare Payment = MAR. In this instance,

   - The 2025 DWC Conversion Factor 70.18
   - The 2025 CMS Conversion Factor 32.3465
   - CMS Physician Fee Schedule Allowable for zip code 79925 (non-facility) $87.11
   - 70.18/32.3465 x $87.11 = $189.00

4. Based on the information available at the time of this review, DWC has found the requester is due $189.00 for code 95886 but zero reimbursement of code 95912 as the submitted documentation does not support the number of tests billed.

Conclusion

The outcome of this medical fee dispute is based on the evidence the requester and the respondent presented at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that reimbursement is due.

Order

Under Texas Labor Code Sections 413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that Texas Mutual must remit to Physiotherapy of El Paso $189.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section 134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 22, 2026 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC Section 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 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 this *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC Section 141.1(d).

Si prefiere hablar con una persona en español acerca de esta correspondencia, favor de llamar a 800-252-7031, opción tres o correo electronico CompConnection@tdi.texas.gov.