Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
San Antonio Injury Rehabilitation

Respondent Name
Edgewood ISD

MFDR Tracking Number
M4-08-3090-01

Carrier's Austin Representative
Box Number 16

MFDR Date Received
January 15, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Pd 2 unit of 6 billed for Range of Motion testing. Denied 4 units "charge exceeds fee schedule allowance". Bill is for testing of multiple rages of motion as related to accepted injury. Per CMS "the code descriptor allows for multiple units to be billed" for the same dos and therefore does not "exceed fee schedule allowance"."

Amount in Dispute: $234.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on a review of the report, provided with the dispute, range of motion measurements of the right shoulder including internal rotation, external rotation, flexion, extension, adduction, and abduction were done. It would appear that the provider charged one unit for each individual measurement, which is incorrect. The American Medical Association CPT Book for 2007 defines 95851 a follows: Range of motion measurements and report (separate procedure): each extremity (excluding hand or each trunk section (spine). Therefore, all of the measurements necessary to evaluate range of motion on the shoulder (one extremity) are included in CPT 95851. Therefore, the provider is only entitled to one unit, not six. The eob mentions something about measurements to the lower extremity. I agree with the provider's Medical Billing Coordinator, Pam Horgan, that no lower extremity measurements were included in the report."

Response Submitted by: Sedgwick CMS, 613 Northwest Loop 410, #800, San Antonio, TX 78216

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 22, 2007	95851	$234.10	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 45 – Charges exceed your contracted / legislated fee arrangement

Issues

1. Did the requestor supplier level of service submitted?
2. Is the requestor entitled to reimbursement?

Findings

1. The respondent stated, "Therefore, the provider is only entitled to one unit, not six." 28 Texas Labor Code §134.203(b) states in the pertinent part, "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." Review of the document "Findings" dated 10/22/2007 shows ROM listed for six range of motion tests of the Upper Extremity (shoulder). Per CPT Code description, "Testing determines active and passive range of motion for extremities and joints. This code applies to manually testing each arm or leg or sections of the spine…" The respondent's statement is supported. No additional payment can be recommended.
2. The Division finds the number of services reported is not supported. Therefore, no payment is due.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October , 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.