



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

R. Edward Roybal, MD

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-15-0143-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

September 11, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The following bill was audited and paid incorrectly. TDI-DWC addresses Return to Work (RTW) and/or Evaluation of Medical Care (EMC Examinations with Rule 134.204, Subsection (k). The Rule states **the reimbursemtn shall be \$500.00 in accordance with subsection (i).** This section also states **testing shall be billed using the appropriate CPT code and reimbursed in addition to the examination fee.** As well, under rule 134.204, Subsection (i)(2) states the first examination shall be reimbursed at 100% of the fee outlined in (k), the second at 50% and subsequent examinations at 25%."

Amount in Dispute: \$83.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of **10/22/2013**. The requester performed an extent of injury exam on the date above then billed Texas Mutual code 99456-W6-RE and code 3 units of 95851, range of motion testing. Texas Mutual paid \$500.00 for the exam and declined to issue payment indicating the testing is bundled to the reimbursement of the 99456-W6.

The requestor cites Rule 134.204 (k) as the basis for its expectation of payment for the range of motion testing Texas Mutual does not agree. The Rule makes no reference to separate payment of the testing when performing extent of injury exams.

No payment is due."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 22, 2013	Range of Motion Testing	\$83.88	\$83.88

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.204 sets out the procedures for billing and reimbursement of Designated Doctor Examinations.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
From the Explanation of Benefits dated 12/02/2013
 - CAC-W1 – Workers Compensation State Fee Schedule Adjustment
 - CAC-97 – The benefit for this service is included in the payment/allowance for another service /procedure that has already been adjudicated.
 - 217 – The value of this procedure is included in the value of another procedure performed on this date.
 - 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.From the Explanation of Benefits dated 01/24/2014
 - CAC-W1 – Workers Compensation State Fee Schedule Adjustment
 - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - CAC-97 – The benefit for this service is included in the payment/allowance for another service /procedure that has already been adjudicated.
 - 217 – The value of this procedure is included in the value of another procedure performed on this date.
 - 724 – No additional payment after a reconsideration of services. For information call 1-800-937-6824
 - 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.

Issues

1. What are the appropriate rules to determine billing for extent of injury issues in a Designated Doctor's examination?
2. May additional testing be billed separately from the Extent of Injury examination?
3. What is the correct MAR for CPT Code 95851?
4. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204 (i)(1)(C), "Extent of the employee's compensable injury shall be **billed and reimbursed in accordance with subsection (k)** of this section, with the use of the additional modifier 'W6'" [emphasis added]. Therefore, the correct rule to determine billing for extent of injury issues in a Designated Doctor's examination is 28 Texas Administrative Code §134.204 (k).
2. Per 28 Texas Administrative Code §134.204 (k), "The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier 'RE.' In either instance of whether MMI/IR is performed or not, the reimbursement shall be \$500 in accordance with subsection (i) of this section and shall include Division-required reports. **Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee**" [emphasis added]. Therefore, additional testing may be billed separately from the Extent of Injury examination.
3. Procedure code 95851, service date October 22, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.16 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.16. The practice expense (PE) RVU of 0.37 multiplied by the PE GPCI of 0.979 is 0.36223. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.826 is 0.00826. The sum of 0.53049 is multiplied by the Division conversion factor of \$55.30 for a MAR of \$29.34 at 3 units is \$88.02.

Note that additional testing is not subject to Per 28 Texas Administrative Code §134.204 (i)(2), as this rule applies to examinations found in section (1)(C)-(F) of the same rule and the testing is billed in addition to those examinations.

4. The total allowable reimbursement for the services in dispute is \$88.02. The amount previously paid by the insurance carrier is \$0.00. The requestor is seeking additional reimbursement in the amount of \$83.88. The requestor is entitled to reimbursement of \$83.88.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$83.88.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$83.88 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	January 2, 2015
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 in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).

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