



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Richard Lawrence, M.D.

Respondent Name

State Office of Risk Management

MFDR Tracking Number

M4-15-4163-01

Carrier's Austin Representative

Box Number 45

MFDR Date Received

August 26, 2015

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 reimbursement shall be \$500.00 in accordance with subsection (i).** This section also states **testing shall be billed using the appropriate CPT codes & reimbursed in addition to the examination fee.**"

Amount in Dispute: \$78.69

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office respectfully requests the division issue a Finding & Decision indicating the requestor ... is entitled to \$0.00 reimbursement for CPT code 95851 based on failure to meet its burden to substantiate that range of motion testing is not inclusive to the complete physical examination (99456) performed and billed by the same doctor on 3/27/2015 to address the Return to Work inquiry."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 27, 2015	Range of Motion Testing (95851)	\$78.69	\$78.69

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 §127.10 sets out the general procedures for designated doctor examinations.
3. 28 Texas Administrative Code §127.220 sets out the requirements for designated doctor reports.
4. 28 Texas Administrative Code §133.10 sets out the requirements for a complete medical bill.

5. 28 Texas Administrative Code §133.200 sets out the procedures for receipt of a medical bill by the insurance carrier.
6. 28 Texas Administrative Code §134.203 sets out the guidelines for billing and reimbursement of professional medical services.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 97 – Recommended allowance made for two/co surgeon.
 - B20 – Payment adjusted because procedure/service was partially or fully furnished by another provider.
 - 193 – Original payment decision is being maintained. This claim was processed properly the first time.
 - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. What is the Maximum Allowable Reimbursement (MAR) for the disputed service?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code B20 – "PAYMENT ADJUSTED BECAUSE PROCEDURE/SERVICE WAS PARTIALLY OR FULLY FURNISHED BY ANOTHER PROVIDER." Review of the submitted information finds that no other provider was referenced in relation to the disputed service. In accordance with 28 Texas Administrative Code §133.200 (a), the insurance carrier accepted the submitted bill as a complete medical bill as defined by 28 Texas Administrative Code §133.10.

The insurance carrier referenced the procedural rules in 28 Texas Administrative Code §127.10 and §127.220 in their position statement as reasons for denial of payment. 28 Texas Administrative Code §133.307 (d)(2)(F) states, in relevant part, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." The submitted documentation does not support that these procedural rules were presented to the requestor prior to the date the request for MFDR was filed. Therefore, these denial reasons will not be considered in this dispute.

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

2. The dispute involves CPT code 95851, which is subject to the fee guidelines in 28 Texas Administrative Code §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. The Division conversion factor for 2015 is \$56.20.

For CPT Code 95851 on March 27, 2015, the relative value (RVU) for work of 0.16 multiplied by the geographic practice cost index (GPCI) for work of 1.000 is 0.160000. The practice expense (PE) RVU of 0.35 multiplied by the PE GPCI of 0.920 is 0.322000. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.822 is 0.008220. The sum of 0.490220 is multiplied by the Division conversion factor of \$56.20 for a total of \$27.55. This total is multiplied by 3 units for a MAR of \$82.65.

3. The total MAR for the disputed services is \$82.65. The requestor is seeking \$78.69. The insurance carrier paid \$0.00. A reimbursement of \$78.69 is recommended.

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 \$78.69.

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 \$78.69 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	<u>Laurie Garnes</u>	<u>September 17, 2015</u>
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, 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 MFDR 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.