



# 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**

Huntley Chapman, M.D.

**Respondent Name**

Federal Insurance Company

**MFDR Tracking Number**

M4-16-1913-01

**Carrier's Austin Representative**

Box Number 17

**MFDR Date Received**

March 7, 2016

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "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:** \$56.26

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "In this matter, Requestor was paid correctly for the examination to determine the extent of the Claimant's injury using DWC Rule 134.204(i)(C). Therefore, no additional reimbursement is owed for this portion of the examination.

Requestor did not perform a return to work examination or an evaluation of medical care examination. He only evaluated the extent of the Claimant's compensable injury. No testing was required to evaluate the extent of the compensable injury. Thus, the range of motion testing was not necessary to determine the extent of the injury and was inclusive in the examination performed by the Requestor. Separate reimbursement is not owed."

**Response Submitted by:** Downs-Stanford, P.C.

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 18, 2015	Range of Motion Testing	\$56.26	\$55.10

### 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 §134.203 sets out the fee guidelines for professional medical services.
3. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 97 – Charge included in another Charge or Service
  - 838 – Included in another billed procedure

### 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 reimbursement for the disputed service?

### Findings

1. The requestor is seeking reimbursement for range of motion testing billed in addition to a designated doctor examination to determine the extent of the compensable injury. The insurance carrier denied disputed services with claim adjustment reason codes 97 – “Charge included in another Charge or Service,” and 838 – “Included in another billed procedure. 28 Texas Administrative Code §134.204(i)(1)(C) requires that the “Extent of the employee’s compensable injury shall be billed and reimbursed **in accordance with subsection (k)** [emphasis added] of this section, with the use of the additional modifier ‘W6.’”

28 Texas Administrative Code §134.204(k) states,

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].

The division finds that 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 disputed service, represented by the procedure code 95851, is a professional medical service subject to the fee guidelines found in 28 Texas Administrative Code §134.203, which states, in relevant part:
  - (c) To determine the 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 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 September 18, 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 2 units for a MAR of \$55.10.

3. The total MAR for the disputed service is \$55.10. The insurance carrier paid \$0.00. A reimbursement of \$55.10 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 \$55.10.

***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 in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$55.10 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

	Laurie Garnes	April 20, 2016
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.**