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
Kristian Fields, D.C.

Respondent Name
Hanover Lloyds Insurance Company

MFDR Tracking Number
M4-18-3810-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
June 5, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "95851 ROM Pays at 28.13 Per Unit … 3 Units Performed = 84.39"

Amount in Dispute: $84.39

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on review of the requestor's submitted medical billing, narrative and DD Examination Data Report CorVel found no evidence of a separately identifiable procedure performed on the same day as the designated doctor evaluation to address extent of injury."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 3, 2017	Range of Motion Testing (95851 x 3)	$84.39	$83.49

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 of professional medical services.
3. 28 Texas Administrative Code §134.235 sets out the fee guidelines for examinations to determine the extent of the compensable injury.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – Charge Included in another Charge or Service
   - R38 – Included in another billed procedure

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. Is the requestor entitled to reimbursement for the services in question?

Findings

1. Kristian Fields, D.C. is seeking reimbursement for range of motion testing performed in conjunction with an examination to determine the extent of the compensable injury. Hanover Lloyds Insurance Company (Hanover Lloyds) denied the services as bundled or included in the examination.

   An examination by a designated doctor to determine the extent of a compensable injury, represented by CPT code 99456 with modifiers "W6" and "RE," is a division-specific service not subject to Medicare billing rules. If the doctor determines that additional testing is required to make a determination, the testing "be billed using the appropriate CPT codes and reimbursed in addition to the examination fee."[1]

   The division finds that range of motion testing is separately payable when performed with an examination to determine the extent of a compensable injury. Hanover Lloyds' denial of payment is not supported.

2. Documentation submitted to the division supports that Dr. Fields performed range of motion testing for the shoulder, knee, and spine. Range of motion testing, represented by CPT code 95851, is billed at one unit for each extremity and the spine. Therefore, Dr. Fields is entitled to reimbursement of these services at three units.

   Reimbursement for the services in question are based on Medicare policies using the conversion factor determined by the division for the appropriate year.[2] The conversion factor for 2017 is $57.50.[3] Therefore, the maximum allowable reimbursement is $83.49. This amount 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 $83.49.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $83.49, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	February 8, 2019 Date

[1] 28 Texas Administrative Code §134.235

[2] 28 Texas Administrative Code §134.203(b) and (c)

[3] https://www.tdi.texas.gov/bulletins/2018/documents/001718table.pdf#CY2019 Table of Conversion Factors

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §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 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. **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.