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**
Jerry Vitek, D.C.

**Respondent Name**
Zurich American Insurance Company

**MFDR Tracking Number**
M4-19-2070-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
December 11, 2018

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "THE CURRENT RULES ALLOW REIMBURSEMENT"

**Amount in Dispute:** $862.52

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The carrier has paid the provider $750.00 … However, the provider is not entitled to anything beyond $750.00 plus interest in light of the fact that his exams were limited to direct result of disability and ability to return to work."

**Response Submitted by:** Flahive, Ogden & Latson

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| May 3, 2018 | 99456-W7-RE | $500.00 | $0.00 |
| May 3, 2018 | 99456-W8-RE | $250.00 | $0.00 |
| May 3, 2018 | Range of Motion 95851 (x4) | $112.52 | $112.52 |

## *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 by designated doctors for questions other than MMI/IR.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.

**Issues**

1. Have some services in this dispute been reimbursed?
2. Are the insurance carrier's reasons for denial of payment supported?
3. Is the requestor entitled to reimbursement for the services in question?

**Findings**

1. Jerry Vitek, D.C. included a request for reimbursement for designated doctor examinations to determine if disability was related to the compensable injury and the injured employee's ability to return to work. Per explanation of benefits dated January 3, 2019, Zurich American Insurance Company reimbursed these examinations in full.

   Because these examinations were reimbursed in full, the division will not consider them in this dispute.

2. Dr. Vitek is also seeking reimbursement for range of motion testing performed in conjunction a designated doctor examination to determine if disability was related to the compensable injury and the injured employee's ability to return to work. Zurich American Insurance Company denied the services as included in the examinations.

   An examination by a designated doctor for examinations by designated doctors for questions other than maximum medical improvement and impairment rating, represented by CPT code 99456 with appropriate modifiers 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 **shall** "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 the disputed division-specific services. Zurich American Insurance Company's denial of payment is not supported.

3. Documentation submitted to the division supports that Dr. Vitek performed range of motion testing for the cervical spine, lumbar spine, and both lower extremities. Range of motion testing, represented by CPT code 95851, is billed at one unit for each extremity and each trunk section (spine). Therefore, Dr. Vitek is entitled to reimbursement of these services at four units, as billed.

   Reimbursement for the testing in question is based on Medicare policies using the conversion factor determined by the division for the appropriate year.[2] The conversion factor for 2018 is $58.31.[3] Therefore, the maximum allowable reimbursement is $133.01. Dr. Vitek is seeking $112.52. 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 $112.52.

[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

## *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 $112.52, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

| | Laurie Garnes | March 13, 2019 |
|---|---|---|
| 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 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**.