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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PACIFIC BILLING

Respondent Name
El Paso ISD

MFDR Tracking Number
M4-20-0324-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
October 2, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "TESTING IS NOT INCLUDED WITH AN RE EXAM"

Amount in Dispute: $78.69

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of adjudication.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 26, 2019	Range of Motion Testing	$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 (DWC).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.235 sets out the fee guidelines for examinations to determine extent of injury.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 309 – The charge for this procedure exceeds the fee schedule allowance.
   - 6512 – Payment is included in the allowance of another procedure and is not separately reimbursable.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - W3 – Additional payment made on appeal/reconsideration.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

- 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. Did El Paso ISD respond to the medical fee dispute?
2. Is the insurance carrier's reason for denial of payment supported?
3. Is Pacific Billing entitled to reimbursement for the service in question?

Findings

1. The Austin insurance carrier representative for El Paso ISD is Downs Stanford, PC. The representative received the copy of this medical fee dispute on October 9, 2019. If the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.[1]

   As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

2. Pacific Billing is seeking reimbursement for range of motion testing performed in conjunction with a designated doctor examination to determine the extent of the compensable injury. The insurance carrier denied reimbursement based on bundling of the service with the examination.

   The insurance carrier is directed to reimburse any testing that a designated doctor, ordered by the DWC, is required to perform in order to determine extent of the compensable injury.[2] The DWC concludes that the insurance carrier's denial of payment is not supported.

3. An examination by a designated doctor to determine the extent of a compensable injury 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."[3]

   Documentation submitted to the DWC supports that Robert Jaehne, D.C. performed range of motion testing for the lumbar spine and bilateral shoulder, elbow, and wrist. Range of motion testing, represented by CPT code 95851, was billed at one unit for each extremity and the spine. Therefore, Pacific Billing is entitled to reimbursement of this service at three units.

   Reimbursement for the service in question is based on Medicare policies using the conversion factor set by the DWC for the appropriate year.[4] The conversion factor for 2019 is $59.19.[5] Therefore, the maximum allowable reimbursement is $99.78. Pacific Billing is seeking $78.69. This amount is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $78.69.

[1] 28 TAC §133.307(d)(1)
[2] 28 TAC §134.235
[3] 28 TAC §134.235
[4] 28 TAC §134.203(b) and (c)
[5] 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 DWC has determined the requestor is entitled to additional reimbursement for the disputed services.
The DWC hereby ORDERS the respondent to remit to the requestor $78.69, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	December 12, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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.