Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
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512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
GILBERT GONZALES, DC

Respondent Name
HARTFORD CASUALTY INSURANCE CO

MFDR Tracking Number
M4-20-1259-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
JANUARY 21, 2020

REQUESTOR'S POSITION SUMMARY

"The patient was in our office for Range of Motion MMT to the compensable injury….According to the OGD Guidelines that we have installed in our system it does not state anything about having to get pre-authorization for the Range of Motion Testing."

Amount in Dispute: $960.00

RESPONDENT'S POSITION SUMMARY

"Dates of service in dispute were denied as muscle testing was not authorized per Rule 134.600(4)."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 4, 2019	CPT Code 95831	$840.00	$725.90
	CPT Code 95832	$60.00	$51.26
	CPT 95851	$60.00	$33.26
TOTAL		$960.00	$810.42

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code §133.307 (TAC), effective May 31, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 TAC §180.22, effective January 9, 2011 requires the treating doctor to coordinate the claimant's health care.

3. 28 TAC §134.600, effective November 1, 2018, requires preauthorization for specific treatments and services.
4. 28 TAC §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
5. Per the submitted explanation of benefits, the services in dispute were reduced/denied by the respondent with the following claim adjustment reason codes:
   - 197-Precertification/authorization/notification/pre-treatment absent.
   - 15-Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
   - 293-This procedure requires prior authorization and none was identified.
   - AUTH-Payment denied/reduced for absence of or exceeded, pre-certification/authorization. Pre-authorization was not obtained and treatment was rendered without the approval of treaing doctor.
   - W3-Additional payment made on appeal/reconsideration.
   - APPR-Reimbursemnt is being withheld as the treating doctor and/or services rendered were not approved based upon handler review.

Issues

Is the requestor entitled to reimbursement for services rendered on June 4, 2019?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $960.00 for CPT codes 95831,95832, and 95851 rendered on June 4, 2019.
2. The respondent denied reimbursement for the disputed services based upon "APPR-Reimbursemnt is being withheld as the treating doctor and/or services rendered were not approved based upon handler review."

   28 TAC §180.22(c)(1) states, "The treating doctor is the doctor primarily responsible for the efficient management of health care and for coordinating the health care for an injured employee's compensable injury. The treating doctor shall: (1) except in the case of an emergency, approve or recommend all health care reasonably required that is to be rendered to the injured employee including, but not limited to, treatment or evaluation provided through referrals to consulting and referral doctors or other health care providers, as defined in this section."

   The DWC reviewed the submitted medical bill that indicates the referring doctor was Douglas W. Burke. Because Dr. Burke is the claimant's treating doctor, the respondent's denial of payment based upon "APPR" is not supported.
3. The respondent also denied reimbursement for the disputed services based upon a lack of preauthorization.

   28 TAC §134.600(p) lists the non-emergency treatment/services that require preauthorization. A review of the the list finds it does not include the disputed range of motion and muscle testing services. Therefore, the respondent's denial is not supported.
4. The fee guidelines for professional services are found in 28 TAC §134.203.
5. To determine the MAR for CPT codes 95831,95832, and 95851 the DWC refers to 28 TAC §134.203(c)(1)(2).

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "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. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (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 following hypothetical example illustrates this annual adjustment activity if the DWC had been using this MEI annual percentage adjustment: The 2006 DWC conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) DWC conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

- CPT Code 95831:

  Place of Service 11
  The 2019 DWC Conversion Factor is 59.19
  The 2019 Medicare Conversion Factor is 36.0391
  The services were rendered in zip code 78224, which is located in San Antonio, Texas; therefore the Medicare carrier locality is "Rest of Texas."
  Medicare participating amount at this locality is $31.57
  Using the above formula, the DWC finds the MAR is $51.85. The requestor billed for 14 units; therefore, 14 X $51.85 = $725.90. The respondent paid $0.00. As a result, The requestor is due the difference between the MAR and amount paid of $725.90.

- CPT Code 95832:
  Place of Service 11
  The 2019 DWC Conversion Factor is 59.19
  The 2019 Medicare Conversion Factor is 36.0391
  The services were rendered in zip code 78224, which is located in San Antonio, Texas; therefore the Medicare carrier locality is "Rest of Texas."
  Medicare participating amount at this locality is $31.21
  Using the above formula, the DWC finds the MAR is $51.26. The respondent paid $0.00. As a result, The requestor is due the difference between the MAR and amount paid of $51.26.

- CPT Code 95851:
  Place of Service 11
  The 2019 DWC Conversion Factor is 59.19
  The 2019 Medicare Conversion Factor is 36.0391
  The services were rendered in zip code 78224, which is located in San Antonio, Texas; therefore the Medicare carrier locality is "Rest of Texas."
  Medicare participating amount at this locality is $20.25
  Using the above formula, the DWC finds the MAR is $33.26. The respondent paid $0.00. As a result, The requestor is due the difference between the MAR and amount paid of $33.26.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $810.42.

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 DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of $810.42 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	02/20/2020 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 TAC §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 MDR 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 DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.