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
NUEVA VIDA BEHAVIORAL HEALTH

Respondent Name
MERGED AMERICAN & FOREIGN INSURANCE

MFDR Tracking Number
M4-20-2191-01

Carrier's Austin Representative
Box Number 11

MFDR Date Received
May 5, 2020

Response Submitted by:
Sedgwick

REQUESTOR'S POSITION SUMMARY

"According to the OGD Guidelines that we have installed in our system it does not state anything about having to get pre auth please send it to me in writing or where we can find it in or the ODG guidelines."

RESPONDENT'S POSITION SUMMARY

"Retrospective review was completed on 02-11-2020 by exURs for the range of motion testing and manual muscle testing and was adverse. Therefore, bill was denied per adverse determination."

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
June 7, 2019	95831, 95832 and 95851	$960.00	$810.42

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code (TLC) §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 §134.203 sets out the guidelines for billing and reimbursement of professional medical services.
3. 22 Texas Administrative Code §78.13 defines the scope of practice for chiropractors.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 - Workers Compensation jurisdictional fee schedule adjustment.
   - P15 – Workers Compensation medical treatment guideline adjustment
   - P12 – A procedure has been billed which is out of the scope of practice for this provider.

Issue(s)

1. Are the insurance carrier's reasons supported?
2. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services stating, "A procedure has been billed which is out of the scope of practice for this provider." The disputed services involve CPT Codes 95831, 95832 and 95851, which is defined as:
   - 95831 – Muscle testing, manual (separate procedure); with report; extremity (excluding hand) or trunk
   - 95832 – Muscle testing, manual, hand, with or without comparison with normal side
   - 95851 – Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)

   22 Texas Administrative Code §78.13 (c)(1) states, in pertinent part, "In the practice of Chiropractic, licensees of this board provide necessary examination and evaluation services to: (A) Determine the bio-mechanical condition of the spine and musculoskeletal system of the human body including, but not limited to, the following: … (iii) the existence of the structural pathology, functional pathology or other abnormality of the system…"

   Review of the submitted information finds that the insurance carrier's denial reason is not supported, as a result, the requestor is entitled to reimbursement. The disputed services are therefore reviewed per the applicable Division rules and fee guidelines.

   The respondent also denied reimbursement for the disputed services stating, "Workers Compensation medical treatment guideline adjustment."

   28 TAC §134.600(p) lists the non-emergency treatment/services that require preauthorization. A review of the list finds it does not include the disputed range of motion and muscle testing services.

   28 TAC §137.100 does not identify the disputed services as not recommended, as a result, the disputed services did not require preauthorization.

   Therefore, the respondent's denial is not supported and therefore, the requestor is entitled to reimbursement pursuant to 28 TAC §134.203.

2. The disputed CPT Codes are therefore subject to 28 TAC §134.203, which state in relevant part, "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules… (c) … (2) … Subsequent year's conversion factors shall be determined by apply 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."
   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR). The requestor seeks reimbursement for CPT Codes 95831, 95832 and 95851. The division finds the following:
   - The 2019 DWC Conversion Factor is 59.19
   - Place of service "11"
   - The 2019 Medicare Conversion Factor is 36.0391
   - The services were rendered in zip code 78224 located in San Antonio, Texas; therefore, the Medicare carrier locality is "Rest of Texas." Medicare participating amount at this locality is $31.57

- CPT Code 95831 – Using the above formula, the DWC finds the MAR for CPT Code 95831 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 – 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– 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

3. The total MAR for the disputed services is $810.42. The insurance carrier paid $0.00. Therefore, the requestor is entitled to reimbursement of $810.42.

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 $810.42.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of TLC 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 TAC §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 29, 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, 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 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.