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
COX, ANGELA B

Respondent Name
HARTFORD FIRE INSURANCE CO

MFDR Tracking Number
M4-20-2212-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
May 5, 2020

REQUESTOR'S POSITION SUMMARY

"TESTING IS NOT INCLUDED WITH AN RE"

Amount in Dispute: $104.92

RESPONDENT'S POSITION SUMMARY

"The documentation submitted supports our original decision that the testing as documented is inclusive to the Physical Examination: Musculoskeletal Organ System. The review is based on Medicare guidelines."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 16, 2019	Range of Motion Testing x 4	$104.92	$104.92

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 §134.203 sets out the fee guidelines for professional services.
3. 28 Texas Administrative Code §134.235 sets out the fee guidelines for examinations to determine extent of the compensable injury.
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.
   - 309 – The charge for this procedure exceeds the fee schedule allowance.

- 906 – In accordance with clinical based coding edits (national Correct Coding Initiative/Outpatient Code Editor), component code of comprehensive medicine, evaluation and management services procedure (90000-99999) has been disallowed.
- 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.

Issues

Is Angela Cox, D.C. entitled to additional reimbursement for the examination in question?

Findings

An examination by a desiganted 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 "shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee."[1]

Documentation submitted to the DWC supports that Dr. Cox performed range of motion testing for the cervical spine, thoracic spine, and bilateral shoulders. Range of motion testing, represented by CPT code 95851, was billed at one unit for each extremity and segment of the spine. Therefore, Dr. Cox is entitled to reimbursement of these services at four units.

Reimbursement for the services in question are based on Medicare policies using the conversion factor determined by the DWC for the appropriate year.[2] The conversion factor for 2019 is $59.19.[3] Therefore, the maximum allowable reimbursement is $133.03. Dr. Cox is seeking $104.92. 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 $104.92.

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 $104.92, 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	June 25, 2020 Date

[1] 28 TAC §134.235
[2] 28 TAC §134.203(b) and (c)
[3] https://www.tdi.texas.gov/wc/fee/conversionfactors.html#conv

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.