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

Requester Name
TELLEZ, ELILIA MARLENE

Respondent Name
SENTINEL INSURANCE COMPANY LTD

MFDR Tracking Number
M4-21-0160-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
October 1, 2020

REQUESTER'S POSITION SUMMARY

"ROM TESTING IS NOT INCLUDED WITH AN RE EXAM"

Amount in Dispute: $28.13

RESPONDENT'S POSITION SUMMARY

"CPT 95851 for muscle testing, as documented, is inclusive to the physical exam of the E/M service."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 13, 2020	Range of Motion Testing	$28.13	$28.13

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 medical services.
3. 28 Texas Administrative Code §134.235 sets out the fee guidelines for examinations to determine disability and ability to return to work.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 101 – Predetermination: anticipated payment upon completion of services or claim adjudication.
   - Pend – Entitlement to benefits not finally adjudicated. Payment is being withheld pending an investigation of the reasonable and necessity of the treatment.
   - W3 – Additional payment made on appeal/reconsideration.
   - 309 – The charge for this procedure exceeds the fee schedule allowance.

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 247 – A payment or denial has already been recommended for this service.
- 1115 – We find the original review to be accurate and are unable to recommend any additional allowance.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 18 – Exact duplicate claim/service.

Issues

Is Elilia Tellez, D.C. entitled to additional reimbursement for the services in question?

Findings

Dr. Tellez is seeking reimbursement for range of motion testing performed in conjunction with an examination to determine disability and ability of the injured employee to return to work.

Examinations by a designated doctor to determine the ability of the injured employee to return to work and if disability is related to the compensable injury are division-specific services and are 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. Tellez performed range of motion testing for the lumbar spine. Range of motion testing, represented by CPT code 95851, was billed at one unit. Therefore, Dr. Tellez is entitled to reimbursement of these services at one unit.

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 2020 is $60.32.[3] Therefore, the maximum allowable reimbursement is $35.77. Dr. Tellez is seeking $28.13. This amount is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requester has established that additional reimbursement is due. As a result, the amount ordered is $28.13.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requester is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requester $28.13, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		December 2, 2020
Signature	Medical Fee Dispute Resolution Officer	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.