TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Noel Mairena, D.C.

Respondent Name
Travelers Indemnity Co.

MFDR Tracking Number
M4-23-0789-01

Carrier's Austin Representative
Box Number 05

DWC Date Received
December 5, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 2, 2022	Designated Doctor Examination 99456-W6-RE	$0.00	$0.00
	Range of Motion Testing 95851 x 4	$48.09	$38.77
	Total	$48.09	$38.77

Requestor's Position

THE CURRENT RULES ALLOW REIMBURSEMENT

Amount in Dispute: $48.09

Respondent's Position

The Provider contends they are entitled to additional reimbursement for CPT code 95851 (range of motion testing). The Carrier has reviewed the cdocumentation and contends the Provider has been reimbursed at the appropriate amount. The Carrier has reviewed the Maximum Allowable Reimbursement Calculation and contends the reimbursement is correct as calculated.

Response Submitted by: Travelers

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.203 sets out the fee guidelines for professional medical services.

3. 28 TAC §134.235 sets out the fee guidelines for examinations to determine the extent of injury.

Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- 947 – Upheld. No additional allowance has been recommended.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Is Noel Mairena, D.C. entitled to additional reimbursement?

Findings

1. Dr. Mairena is seeking reimbursement for range of motion testing performed in conjunction with a designated doctor examination to determine the extent of a compensable injury. While no explanation of benefits showing payment was included in the submitted documentation, Dr. Mairena indicated on the request for medical fee dispute resolution that $116.31 was paid.

   If the examining doctor determines that additional testing is required to make a determination, 28 TAC §134.235 requires that the testing be billed using the appropriate CPT codes and reimbursed in addition to the examination fee.

   Documentation submitted to DWC supports that Dr. Mairena performed range of motion testing for the right shoulder, left shoulder, right knee and left knee. Range of motion testing, represented by CPT code 95851, was billed at one unit for each extremity. Therefore, Dr. Mairena is entitled to reimbursement of this service at four units.

   As stated in 28 TAC §134.203 (b) and (c), reimbursement for the services in question are based on Medicare policies using the conversion factor determined by DWC for the appropriate year. The conversion factor for 2022 is $62.46. Therefore, the MAR is $155.08. Travelers Indemnity Co. paid $116.31 according to the requestor. An additional

reimbursement of $38.77 is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement of $38.77 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Travelers Indemnity Co.must remit to Noel Mairena, D.C. $38.77 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		February 8, 2023
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.