



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

Sheri Ekukpe, D.C.

Respondent Name

Trumbull Insurance Company

MFDR Tracking Number

M4-18-5296

Carrier's Austin Representative

Box Number 47

MFDR Date Received

August 29, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Testing is Not included in RE Exam."

Amount in Dispute: \$86.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT 95831 muscle testing – based on documentation furnished by the provider, criteria was not met for this charge."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: January 23, 2018, Manual Muscle Testing (95831 x 2), \$86.30, \$86.30

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 §133.203 sets out the fee guidelines for medical services.
3. 28 Texas Administrative Code §134.235 sets out the fee guidelines for examinations to determine the extent of a 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.
- 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.

- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 851 – The allowance was adjusted in accordance with multiple procedure rules and/or guidelines.
- 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.
- 235 – The documentation doesn’t support the level of service billed. Reimbursement was made for a code that is supported by the description and documentation submitted with the billing.
- 1115 – We find the original review to be accurate and are unable to recommend any additional allowance.

## **Issues**

1. Is the insurance carrier’s denial of the disputed service supported?
2. Is the requestor entitled to additional reimbursement?

## **Findings**

1. Sheri Ekupke, D.C. is seeking reimbursement for two units of manual muscle testing of the lower extremity and spine performed in association with a designated doctor examination to determine the extent of the compensable injury, if disability was related to the compensable injury, and the injured employee’s ability to return to work. Trumbull Insurance Company (Trumbull) denied the disputed service based on bundling of charges.

Billing and reimbursement policies for medical services are based on Medicare fee guidelines.<sup>1</sup> The process of bundling procedure codes, including those with the “separate procedure” designation, within workers’ compensation is based on Medicare’s National Correct Coding Initiative (NCCI). The NCCI program provides a listing of procedure-to-procedure (PTP) codes that may not be billed together.<sup>2</sup>

Dr. Ekupke billed the procedure code in question with a division-specific evaluation represented by procedure codes 99456-W6-RE, 99456-W7-RE, and 99456-W8-RE. No other billing codes were included on the submitted bills. Because the billed procedure codes represent services that are specific to Texas workers’ compensation fee guidelines and are not found in the NCCI-PTP listing, the disputed procedure code is not bundled within this service.

Testing that is required to make these determinations are to be billed and reimbursed in addition to the examination fees.<sup>3</sup> Dr. Ekupke billed for two units of Current Procedural Terminology (CPT) code 95831. CPT code 95831 is defined as “Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk.”<sup>4</sup>

Documentation submitted to the DWC supports that manual muscle testing was performed on the right lower extremity and the lumbo-sacral paraspinal muscles. The insurance carrier’s denial is not supported.

2. Because Trumbull failed to support its denial of payment, Dr. Ekupke is eligible for reimbursement of this service.

Health care providers that perform medical services in an office setting apply the Medicare payment policies with minimal modifications.<sup>5</sup>

The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the division conversion factor. The

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<sup>1</sup> 28 Texas Administrative Code §133.203(b)

<sup>2</sup> [https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Downloads/ncci\\_correspondence\\_language\\_manual.pdf](https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Downloads/ncci_correspondence_language_manual.pdf), p. 6

<sup>3</sup> 28 Texas Administrative Code §134.235

<sup>4</sup> American Medical Association, *Current Procedural Terminology, (CPT)*, 2018 Professional Edition

<sup>5</sup> 28 Texas Administrative Code §133.203(c)

division conversion factor for 2018 is \$58.31. The MAR for CPT code 95831, 2 units, is \$109.04. Dr. Ekupke is seeking \$86.30. This amount is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$86.30.

**ORDER**

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$86.30, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

	Laurie Garnes	December 12, 2018
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 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 division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division 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.**