



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Jay Harrison, D.C.

**Respondent Name**

Accident Fund Insurance Co. of America

**MFDR Tracking Number**

M4-24-1833-01

**Carrier's Austin Representative**

Box Number 6

**DWC Date Received**

April 22, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 16, 2023	Designated Doctor Examination 99456-W6-RE	\$00.00	\$00.00
August 16, 2023	95851	\$123.30	\$117.60
<b>Total</b>		\$123.30	\$117.60

### Requestor's Position

"Carrier is required to pay designated doctor exams... The current rules allow reimbursement."

**Amount in Dispute:** \$123.30

### Respondent's Position

"After review of the dispute, Accident Fund believes the bill from the designated doctor was correctly audited."

**Response Submitted By:** Stone, Laughlin & Swanson

## 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 \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.235](#) sets out the fee guidelines for examinations to determine extent of injury, return to work, and disability.
3. [28 TAC §134.240](#) sets out medical fee guidelines for designated doctor examinations.
4. [Texas Labor Code \(TLC\) §408.0041](#) sets out provisions of Designated Doctor examinations under the Texas Workers' Compensation Act.
5. [28 TAC §134.203](#) sets fee guidelines for professional medical services.

### Denial Reasons

The insurance carrier denied the payment for the disputed service with the following claim adjustment codes:

- 243 – The charge for this procedure was not paid since the value of this procedure is included within the value of another procedure performed.

### Issues

1. What service is in dispute?
2. Is the reason for denial of payment for the disputed service supported?
3. Is the requestor entitled to reimbursement?

### Findings

1. On the disputed date of service, the designated doctor, Jay Harrison, D.C., billed for an examination to determine the extent of injury, as was ordered by DWC. The services rendered on August 16, 2023, were billed under CPT code 99456-W6-RE and CPT code 95851 x 3 units. Per the explanation of benefits (EOB) document submitted, CPT code 99456-W6-RE was reimbursed for charges in full, in the amount of \$500.00. Per the EOB submitted, CPT code 95851 was denied reimbursement for all charges and is the only service in dispute according to the DWC060, Request for Medical Fee Dispute Resolution (MFDR).

DWC finds that CPT code 95851 x 3 units is the only service in dispute.

2. Per the EOB submitted, CPT code 95851 was denied because the insurance carrier asserts that procedure 95851 is included in the service of 99456-W6-RE, which was paid for in full.

CPT code 99456-W6-RE describes the service of an examination by a designated doctor to determine the extent of the employee's compensable injury.

CPT code 95851 is "a medical code used by medical professionals to describe the procedure of measuring the range of motion (ROM) in a single extremity or spine section, excluding the hand, and preparing a formal report."

28 TAC §134.235, which applies to the billing and reimbursement of the service in dispute, states, "The following shall apply to return to work (RTW)/evaluation of medical care (EMC) examinations. When conducting a division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT code 99456 with modifier 'RE.' In either instance of whether maximum medical improvement/ impairment rating (MMI/IR) is performed or not, the reimbursement shall be \$500 in accordance with §134.240 of this title and shall include division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee."

In accordance with 28 TAC §134.235, the designated doctor is entitled to separate, additional reimbursement for the rendering of ROM measurements and testing. Therefore, DWC finds that the insurance carrier's reason for denial of CPT code 95851 is not supported.

3. The requestor, Jay Harrison, D.C., is seeking reimbursement in the amount of \$123.30 for an examination rendered on August 16, 2023, for the purpose of determining the extent of the injured employee's compensable injury.

A review of the submitted documentation supports that Dr. Harrison performed a range of motion testing and measurements on two extremities plus the spine in his examination to determine the extent of the compensable injury. According to 28 TAC §134.235, the doctor is entitled to additional reimbursement for the range of motion testing billed under CPT code 95851.

DWC finds that 28 TAC §134.203 applies to the reimbursement of the service in dispute. 28 TAC §134.203 states in pertinent part, "(c) To determine the maximum allowable reimbursement (MAR) for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying 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 = MAR
- The 2023 DWC Conversion Factor is 64.83
- The 2023 Medicare Conversion Factor is 33.8872

- The service in dispute was billed as 3 units of CPT code 95851 on August 16, 2023.
- Per the medical bill submitted, the disputed service was rendered in zip code 76401; Medicare locality 99, "Rest of Texas."
- The Medicare participating amount for CPT code 95851 in locality 99 in 2023, is \$20.49 per unit.
- Using the above formula, DWC finds the MAR for CPT code 95851 x 3 units rendered on the disputed date of service = \$117.60.
- The insurance carrier paid \$0.00 for the disputed service.
- DWC recommends reimbursement in the amount of \$117.60 for the disputed service of CPT code 95851 x 3 units rendered on August 16, 2023.

DWC finds that the requestor, Jay Harrison, D.C., is entitled to reimbursement in the amount of \$117.60 for 3 units of CPT code 95851 rendered on August 16, 2023.

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 requestor has established that reimbursement is due in the amount of \$117.60.

**Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that Accident Fund Insurance Co. of America must remit to Jay Harrison, D.C. \$117.60 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

**Authorized Signature**

		May 17, 2024
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](http://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](mailto: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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).