TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Charles Xeller MD

MFDR Tracking Number M4-25-1091-01

DWC Date Received
January 23, 2025

Respondent Name
Old Republic Insurance Co

Carrier's Austin Representative
Box Number 44

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 3, 2024	99456 W6 RE	$0.00	$0.00
May 3, 2024	95851	$123.30	$123.30
	Total	$123.30	$123.30

Requestor's Position

"DESIGNATED DOCTOR EXAM... CARRIER IS REQUIRED TO PAY DESIGNATED DOCTOR EXAMS... THE CURRENT RULES ALLOW REIMBURSEMENT."

Amount in Dispute: $123.30

Respondent's Position

The Austin carrier representative for Old Republic Insurance Co is White Espey Pllc. The representative was notified of this medical fee dispute on February 4, 2025.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §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) §134.235, effective July 7, 2016, 41 TexReg 4839, sets out the medical fee guidelines for Return to Work/Evaluation of Medical Care examinations.

2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

3. 28 TAC §134.203 sets out the fee guidelines for testing.

Denial Reasons

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

- 18 – Exact duplicate claim/service
- 247 – A payment or denial has already been recommended for this service.

Issues

1. What services are in dispute?

2. What rule is applicable to reimbursement?

3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of code 95851 – "Range of motion measurements and report" rendered on May 3, 2024 as part of a division ordered exam.

   Review of the documentation submitted with this request for MFDR included.

   - Explanation of benefits indicating duplicate denial.
   - Copy of faxed transmission dated July 31, 2024 that indicates, "Please provide an additional 123.30."
   - The insurance carrier (Old Republic Insurance Co) did not submit a position statement or documentation to support the payment denial of the disputed charges.

   Based on this review, the requestor does not seek payment of code 99456 W6 RE but only $123.30 for code 95851 for three units. The division finds that because the insurance carrier did

not support the denial reason for CPT code 95851, the requestor is entitled to reimbursement. The fee calculation per applicable fee guideline is shown below.

2. DWC Rule §134.235 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." [emphasis added.]

   DWC Rule §134.203 (c)(1)(2) states in relevant parts, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. 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… 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…"

   The physician fee schedule allowable amount for a non-facility in Houston, Texas is $21.90

   The DWC Conversion factor for 2024 is 67.81. The Medicare conversion factor is 33.2875. The maximum allowed reimbursement (MAR) is calculated as,

   - 67.81/33.2875 x $21.90 x 3 = $133.84

3. The MAR for three units of code 95851 rendered on May 3, 2024 is $133.84. The requestor is seeking $123.30. This amount 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 requestor has established that additional reimbursement is due.

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 Old Republic Insurance Co must remit to Pacific Billing $123.30 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

	Medical Fee Dispute Resolution Officer	April 23, 2025
Signature		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 three 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 tres o correo electronico CompConnection@tdi.texas.gov.