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

General Information

Requestor Name
Linda Gregory, D.O.

Respondent Name
Dallas ISD

MFDR Tracking Number
M4-25-2086-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
May 1, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 18, 2024	Designated Doctor Examination 99456-W6-RE	$500.00	$500.00
	Designated Doctor Examination 99456-W5-SP	$50.00	$0.00
	Range of Motion Testing 95851	$41.10	$41.10
	Total	$591.10	$541.10

Requestor's Position

"AN ORIGINAL BILL AND A RECONSIDERATION WERE SUBMITTED. THE CURRENT RULES ALLOW REIMBURSEMENT."

Amount in Dispute: $591.10

Respondent's Position

"Dallas ISD received the enclosed CMS 1500 and medical records on 10/30/2024. Argus received this information on 11/01/2024 and audited the bill on 11/11/2024. No allowance was recommended utilizing reduction code 29E:

"The time limit for filing has expired. A HCP shall not submit a medical bill later than the 95th day after the date of services are provided."

Response Submitted by: Argus Claims Management, Inc.

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) §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.210, effective July 7, 2016, 41 TexReg 4839, sets out the fee guidelines for division-specific services.

3. 28 TAC §134.235, effective July 7, 2016, 41 TexReg 4839, sets out the fee guidelines for examinations to determine the extent of injury.

4. 28 TAC §134.250, effective July 7, 2016, 41 TexReg 4839, sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.

Denial Reasons

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

- 29E – The time limit for filing has expired. *A HCP shall not submit a medical bill later than the 95th day after the date of services are provided.*

Issues

1. Is the insurance carrier's denial based on timely filing supported?

2. Is Linda Gregory, D.O. entitled to reimbursement for the services in question?

Findings

1. Dr. Gregory is seeking reimbursement for a designated doctor examination to determine the extent of the compensable injury, including the incorporation of a specialist's report and range of motion testing. The examination in question was performed on date of service May 18, 2024.

The insurance carrier denied payment stating "The time limit for filing has expired. *A HCP shall not submit a medical bill later than the 95th day after the date of services are provided.*"

According to 28 TAC §133.20(b), a health care provider must submit a medical bill to the insurance carrier within 95 days from the date of service with few exceptions.

The greater weight of evidence provided to DWC supports that the requestor submitted a complete medical bill for the examination in question to the insurance carrier on or about August 8, 2024. This is less than 95 days from the date of service.

DWC finds that the denial of payment for this reason is not supported.

2. Because the insurance carrier failed to support its denial of payment for the services in question, DWC will review these services in accordance with fee guidelines.

The submitted documentation indicates that Dr. Gregory performed an examination to determine the extent of the compensable injury. According to 28 TAC §134.235, the MAR for this examination is $500.00.

Dr. Gregory is seeking reimbursement for incorporating a specialist's report into her examination to determine the extent of the compensable injury. This service was billed with procedure code 99456-W5-SP.

28 TAC §134.210(e)(8) states, "SP, specialty area – This modifier shall be added to the appropriate MMI CPT code when a specialty area is **incorporated into the MMI report**." [emphasis added]

28 TAC §134.250(4)(D)(iii) limits billing for incorporating a specialist report into the determination of impairment rating to non-musculoskeletal body areas. Dr. Gregory provided no evidence to support that a specialist's report was used in the final determination of an impairment rating of a non-musculoskeletal body area. The requestor is not entitled to reimbursement for this service.

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. Gregory performed range of motion testing for the spine. Range of motion testing, represented by CPT code 95851, was billed at one unit.

Range of motion testing is a professional service subject to reimbursement policies found in 28 TAC §134.203, which states, in relevant part: "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

(1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and

physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

Reimbursement fee guidelines for professional services are addressed in 28 TAC §134.203(c), which states in relevant part: "To determine the 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 …

(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 …"

Procedure code 95851 is defined as "Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)."

To determine the MAR, the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) x Medicare Participating Amount.

- The DWC conversion factor for date of service May 18, 2024, is 67.81.
- The Medicare conversion factor for 2024 is 33.2875.
- Per the submitted medical bills, the service was rendered in zip code 75243 which is in Medicare locality 0441211.
- The Medicare participating amount for CPT code 95851 is $21.77.

The MAR is calculated as follows: (67.81/33.2875) x $21.77 = $44.35. Dr. Gregory is seeking $41.10 for this service.

The total allowable reimbursement for the services in this dispute is $541.10. 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 reimbursement of $541.10 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 Dallas ISD must remit to Linda Gregory, D.O. $541.10 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 22, 2025 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.