Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALPINE HEALTHCARE CLINIC LP
SUITE 5
1621 NORTH MAIN AVENUE
SAN ANTONIO TX 78211

Respondent Name
BITUMINOUS CASUALTY CORP

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-05-8301-01

MFDR Date Received
May 19, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier has failed to follow this rule. – DOS: 12/30/05 [sic] WITHIN MARS/COMPENSABLE INJURY AFTER REQUEST FOR RECONSIDERATION. – DOS: 12/14/04 WITHIN MARS/1st FCE/ NON GLOBAL AFTER REQUEST FOR RECONSIDERATION. Per TWCC guidelines and protocols all patients with compensable injuries are entitled to 3 Functional Capacity Evaluations."

Amount in Dispute: $501.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Harris & Harris represents Bituminous Insurance Company, in this matter. Please direct all future correspondence regarding this Medical Dispute matter to the undersigned at Harris & Harris."

Response Submitted by: Harris & Harris Attorneys at Law

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
12/14/2004	97750-FC	$407.00	$343.00
12/30/2004	99213 and 99199	$94.00	$0.00
TOTAL		$501.00	$343.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.202 sets out the medical fee guidelines for professional medical services provided on or after September 1, 2002.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits for CPT code 97750-FC
   - G – Unbundling
   - R84 – CCI; Most Extensive Procedures
   - FC – Functional Capacity Evaluations
   - 97 – Charge included in another charge or service
   - W4 – No additional payment allowed after review

   Explanation of benefits for CPT codes 99213 and 99199
   - 150 – Denied per insurance carrier decision
   - E – Entitlement to benefits
   - W4 – No additional payment allowed after review
   - 52 – Provider not eligible for service billed
   - W2 – WC claim adjudicated as non-compensable

Issues

1. What is the appropriate process to resolve Compensability, Extent of Injury and Liability?
2. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305?
3. Is CPT code 97750-FC unbundled with CPT code 96004?
4. Is the requestor entitled to reimbursement?

Findings

1. Unresolved extent-of-injury dispute: The date of service December 30, 2004, contains unresolved issues of compensability, extent-of-injury and or liability for date of service December 30, 2004. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical billing process.

   Dispute resolution sequence: 28 Texas Administrative Code §133.305(b) requires that compensability, extent-of-injury and liability disputes be resolved prior to the submission of a medical fee dispute for the same services.

   Compensability, Extent-of-injury and Liability dispute process: The appropriate process to resolve compensability, extent-of-injury and liability, including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1.
2. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury.

   28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021."

   Review of the submitted documentation finds that there are unresolved issues of compensability, extent and/or liability for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of compensability, extent and/or liability have been resolved for date of service December 30, 2004, prior to the filing of the request for medical fee dispute resolution.

   The requestor has failed to establish that the respondent's denial of payment reasons concerning compensability, extent of injury or liability for the injured employee's workers' compensation claim have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 410 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment for date of service December 30, 2004 in this medical fee dispute. As a result, no amount is ordered for date of service December 30, 2004.

3. Per 28 Texas Administrative Code § 134.202 "(e) Payment policies relating to coding, billing, and reporting for commission-specific codes, services, and programs are as follows: (4) Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the commission shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using the "Physical performance test or measurement..." CPT code with modifier "FC." FCEs shall be reimbursed in accordance with subsection (c) (1). Reimbursement shall be for up to a maximum of four hours for the initial test or for a commission ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required. FCEs shall include the following elements."

   The requestor seeks reimbursement for CPT code 97750-FC defined as a functional capacity evaluation. CPT code 97750-FC is not bundled to CPT code 96004. The requestor appended modifier –FC to identify that the disputed service is a functional capacity evaluation.

   CPT code 97750 when billed without the modifier –FC is defined as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes," and bundles with CPT code 96004. The requestor however is billing for a functional capacity evaluation. No bundled edits apply to these two codes sets. As a result, the requestor is entitled to reimbursement for CPT code 97750-FC. The disputed charge will be reviewed pursuant to 28 Texas Administrative Code §134.202.
4. Per 28 Texas Administrative Code §134.202 "(e) Payment policies relating to coding, billing, and reporting for commission-specific codes, services, and programs are as follows: (4) Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the commission shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using the 'Physical performance test or measurement...' CPT code with modifier 'FC.' FCEs shall be reimbursed in accordance with subsection (c) (1). Reimbursement shall be for up to a maximum of four hours for the initial test or for a commission ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required. FCEs shall include the following elements."
5. Review of the submitted documentation finds that the requestor billed for 11 units of CPT code 97750. Units are 11 units at 15 minute increments equates to 2 hours and 45 minutes. The requestor documented 2 ½ hours of a functional capacity evaluation. Therefore the requestor is entitled to $34.30 x 10 units for a total reimbursement of $343.00.

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 $343.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $343.00 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 20, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.