



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

SUMMIT REHABILITATION CENTERS

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number

M4-07-0026-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

August 29, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DOS 1/4/06, 1/9/06 (99213), 1/11/06 (99213), 1/16/06 (99213), 1/18/06 (98940 & 99213), and 1/20/06: All office visits to the treating doctor are well informed here and during initial billing of services. . . . DOS 1/9/06 (96004 & 98940), 3/14/06 (FCE), 3/23/06 and 4/28/06: Services are not global or incidental to any other treatment on those dates. . . . DOS 1/11/06 through 1/20/06: All the physiotherapy was **preauthorized**, included please find authorization letters. . . . DOS 1/24/06, 3/14/06 and 5/22/06: Provider followed fee guidelines to bill for services. . . . DOS 2/14//06: The document is not a duplicate charge, off work slip has not been paid yet."

Amount in Dispute: \$2,693.39

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This dispute involves Texas Mutual's denial of payment for several different codes over a number of dates from 1/4/2006 through 5/22/2006. The requestor billed \$2,988.00; Texas Mutual paid \$185.74."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, Texas 78723

SUMMARY OF FINDINGS

| Date(s) of Service | Disputed Services | Amount In Dispute | Amount Due |
|---------------------------------|-------------------------------|-------------------|------------|
| January 4, 2006 to May 22, 2006 | Professional Medical Services | \$2,693.39 | \$468.10 |

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 §133.1 defines words and terms related to medical benefits.
2. 28 Texas Administrative Code §133.305 sets out general provisions related to medical dispute resolution.
3. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §133.308 sets out rules for independent review of medical necessity disputes.
5. 28 Texas Administrative Code §129.5 sets out guidelines regarding work status reports.
6. 28 Texas Administrative Code §134.202 sets out the fee guidelines for professional medical services.
7. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective review of health care.

8. This request for medical fee dispute resolution was received by the Division on August 29, 2006. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on September 7, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.
9. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 18 – DUPLICATE CLAIM/SERVICE.
 - 217 – THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE.
 - 224 – DUPLICATE CHARGE.
 - 247 – EVIDENCE DOES NOT SUPPORT THE NEED FOR THE DURATION, INTENSITY AND/OR SERVICES BILLED.
 - 248 – DWC-73 NOT PROPERLY COMPLETED OR SUBMITTED IN EXCESS OF THE FILING REQUIREMENT; REIMBURSEMENT DENIED PER RULE 129.5.
 - 281 – FUNCTIONAL CAPACITY EVALUATIONS ARE ALLOWED A MAXIMUM OF FOUR HOURS-FOR AN INITIAL OR THREE TIMES FOR EACH INJURED WORKER.
 - 42 – CHARGES EXCEED OUR FEE SCHEDULE OR MAXIMUM ALLOWABLE AMOUNT.
 - 435 – PER NCCI EDITS, THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF THE COMPREHENSIVE PROCEDURE.
 - 57 – PAYMENT DENIED/REDUCED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE, THIS MANY SERVICES, THIS LENGTH OF SERVICE, THIS DOSAGE, OR THIS DAY'S SUPPLY.
 - 62 – PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION.
 - 790 – THIS CHARGE WAS REDUCED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.
 - 858 – PHYSICAL MEDICINE AND REHABILITATION SERVICES MAY NOT BE REPORTED IN CONJUNCTION WITH AN E/M CODE PERFORMED ON THE SAME DAY.
 - 864 – E/M SERVICES MAY BE REPORTED ONLY IF THE PATIENT'S CONDITION REQUIRES A SIGNIFICANT SEPARATELY IDENTIFIABLE E/M SERVICE.
 - 930 – PRE-AUTHORIZATION REQUIRED, REIMBURSEMENT DENIED.
 - 97 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE.
 - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT

Findings

1. Are there unresolved issues of medical necessity related to disputed services?
2. Did the insurance carrier make previous payment on a duplicate billing?
3. Was the disputed work status report submitted in accordance with the filing requirements of the rule?
4. Were the disputed services preauthorized?
5. What is the recommended reimbursement for the disputed services?
6. Is the requestor entitled to additional payment for the disputed services?

Findings

1. The insurance carrier denied procedure code 98940, service dates January 4, January 9, January 18 and January 20, 2006 with reason code 247 – “EVIDENCE DOES NOT SUPPORT THE NEED FOR THE DURATION, INTENSITY AND/OR SERVICES BILLED.” Per former rule at 28 Texas Administrative Code §133.305(a)(2), effective January 1, 2003, 27 *Texas Register* 12282 "Medical Fee Disputes involve a dispute over the amount of payment for health care rendered to an injured employee and determined to be medically necessary and appropriate for treatment of that employee's compensable injury. The dispute is for reasons other than the medical necessity of the care." Subsection 133.305(b) requires that “If there is a medical necessity dispute for which there are medical fee components, the requestor shall file a request for medical dispute resolution with the commission. The medical necessity dispute will be resolved pursuant to §133.308 of this title prior to deciding the medical fee dispute pursuant to §133.307 of this title.” Per former rule at 28 Texas Administrative Code §133.307(a), “Medical necessity is not an issue in a medical fee dispute.” Subsection 133.307(g)(2) requires that “If the request contains unresolved medical necessity issues, the commission shall notify the parties of the review requirements pursuant to §133.308.” The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that there are unresolved issues of medical necessity for services for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution; therefore, such disputed services will not be considered in this review.

2. The insurance carrier denied disputed work status report 99080-73, service date February 14, 2006, with reason codes 18 – "DUPLICATE CLAIM/SERVICE" and 224 – "DUPLICATE CHARGE." The insurance carrier's position statement asserts that "Texas Mutual paid previously the billing of this code for date 2/14//06." The insurance carrier submitted an explanation of benefits supporting previous payment of this service at the Division specified rate. The insurance carrier's denial reason is supported. Additional reimbursement is not recommended.
3. The insurance carrier denied disputed work status report 99080-73, service date March 14, 2006, with reason code 248 – "DWC-73 NOT PROPERLY COMPLETED OR SUBMITTED IN EXCESS OF THE FILING REQUIREMENT; REIMBURSEMENT DENIED PER RULE 129.5." Per 28 Texas Administrative Code §129.5(d), "The doctor shall file the Work Status Report: (1) after the initial examination of the employee, regardless of the employee's work status; (2) when the employee experiences a change in work status or a substantial change in activity restrictions; and (3) on the schedule requested by the insurance carrier (carrier), its agent, or the employer requesting the report through its carrier, which shall not to exceed one report every two weeks and which shall be based upon the doctor's scheduled appointments with the employee." Review of the submitted work status report finds that the report was not submitted in relation to an initial examination of the employee. No documentation was found of a change in work status or a substantial change in activity restrictions. No documentation was found to support that the report was requested by the insurance carrier, its agent, or the employer. The Division concludes that the insurance carrier's denial reasons are supported. Reimbursement is not recommended.
4. The insurance carrier denied disputed services including procedure code 97035, service dates January 18, and January 20, 2006; procedure code 97110, service dates January 11, January 16, January 18, and January 20, 2006; procedure code 97112, service dates January 18, and January 20, 2006; procedure code 97116, service dates January 11, and January 16, 2006; procedure code 97530, service date January 20, 2006; and procedure code 97140-59, service dates January 18, and January 20, 2006, with reason codes 62 – "PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION" and 930 – "PRE-AUTHORIZATION REQUIRED, REIMBURSEMENT DENIED." Former Emergency Rule at 28 Texas Administrative Code §134.600(b), effective December 1, 2005, states in pertinent part that "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (h) or (i) of this section, only when the following situations occur: (A) an emergency, as defined in §133.1 of this title (relating to Definitions); (B) preauthorization of any health care listed in subsection (h) of this section was approved prior to providing health care." §134.600(h)(15) states that the non-emergency health care requiring preauthorization includes physical and occupational therapy services rendered on or after December 1, 2005. The requestor's position statement asserts that "All the physiotherapy was preauthorized, included please find authorization letters." Review of the submitted information finds no documentation to support that the above services were preauthorized. The insurance carrier's denial reasons are supported; therefore, additional reimbursement cannot be recommended.
5. This dispute relates to professional physical therapy and rehabilitation services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.202, effective January 5, 2003, 27 *Texas Register* 4048 and 12304, which requires that "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided" with any additions or exceptions as set forth in the rule. Subsection 134.202(c) requires that "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used. (2) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule." Reimbursement for the disputed services is calculated as follows:
 - Procedure code 99213, service date January 4, 2006, was denied with reason codes 57 – "PAYMENT DENIED/REDUCED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE, THIS MANY SERVICES, THIS LENGTH OF SERVICE, THIS DOSAGE, OR THIS DAY'S SUPPLY." and 864 – "E/M SERVICES MAY BE REPORTED ONLY IF THE PATIENT'S CONDITION REQUIRES A SIGNIFICANT SEPARATELY IDENTIFIABLE E/M SERVICE." 28 Texas Administrative Code §134.202 requires that system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided. Per Medicare policy, procedure code 99213 is unbundled. This procedure is a component service of procedure code 98940 performed on the same date. Payment for this service is included in the payment for other services performed. Separate payment is not recommended.

- Procedure code 96004, service date January 9, 2006, is defined as physician review and interpretation of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report. Motion analysis is performed in a dedicated motion analysis laboratory (ie, a facility capable of performing videotaping from the front, back and both sides, computerized 3-D kinematics, 3-D kinetics, and dynamic electromyography). Review of the clinical notes submitted by the requestor finds that the tests reviewed by the physician were not performed in a dedicated motion analysis laboratory and did not meet the description of the required tests as set out in the code's definition. The documentation submitted by the requestor does not support the service as billed; therefore, payment cannot be recommended.
- Procedure code 99213, service date January 9, 2006, was denied with reason codes 57 – "PAYMENT DENIED/REDUCED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE, THIS MANY SERVICES, THIS LENGTH OF SERVICE, THIS DOSAGE, OR THIS DAY'S SUPPLY." and 864 – "E/M SERVICES MAY BE REPORTED ONLY IF THE PATIENT'S CONDITION REQUIRES A SIGNIFICANT SEPARATELY IDENTIFIABLE E/M SERVICE." 28 Texas Administrative Code §134.202 requires that system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided. Per Medicare policy, procedure code 99213 is unbundled. This procedure is a component service of procedure code 98940 performed on the same date. Payment for this service is included in the payment for other services performed. Separate payment is not recommended.
- Procedure code 99213, service date January 11, 2006, was denied with reason codes 57 – "PAYMENT DENIED/REDUCED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE, THIS MANY SERVICES, THIS LENGTH OF SERVICE, THIS DOSAGE, OR THIS DAY'S SUPPLY." and 864 – "E/M SERVICES MAY BE REPORTED ONLY IF THE PATIENT'S CONDITION REQUIRES A SIGNIFICANT SEPARATELY IDENTIFIABLE E/M SERVICE." 28 Texas Administrative Code §134.202 requires that system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided. Per Medicare policy, procedure code 99213 is unbundled. This procedure is a component service of procedure code 98940 performed on the same date. Payment for this service is included in the payment for other services performed. Separate payment is not recommended.
- Procedure code 99213, service date January 16, 2006, was denied with reason codes 57 – "PAYMENT DENIED/REDUCED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE, THIS MANY SERVICES, THIS LENGTH OF SERVICE, THIS DOSAGE, OR THIS DAY'S SUPPLY." and 864 – "E/M SERVICES MAY BE REPORTED ONLY IF THE PATIENT'S CONDITION REQUIRES A SIGNIFICANT SEPARATELY IDENTIFIABLE E/M SERVICE." 28 Texas Administrative Code §134.202 requires that system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided. Per Medicare policy, procedure code 99213 is unbundled. This procedure is a component service of procedure code 98940 performed on the same date. Payment for this service is included in the payment for other services performed. Separate payment is not recommended.
- Procedure code 99213, service date January 18, 2006, was denied with reason codes 57 – "PAYMENT DENIED/REDUCED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE, THIS MANY SERVICES, THIS LENGTH OF SERVICE, THIS DOSAGE, OR THIS DAY'S SUPPLY." and 858 – "PHYSICAL MEDICINE AND REHABILITATION SERVICES MAY NOT BE REPORTED IN CONJUNCTION WITH AN E/M CODE PERFORMED ON THE SAME DAY." 28 Texas Administrative Code §134.202 requires that system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided. Per Medicare policy, procedure code 99213 is unbundled. This procedure is a component service of procedure code 98940 performed on the same date. Payment for this service is included in the payment for other services performed. Separate payment is not recommended.
- Procedure code 99213, service date January 20, 2006, was denied with reason codes 57 – "PAYMENT DENIED/REDUCED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE, THIS MANY SERVICES, THIS LENGTH OF SERVICE, THIS DOSAGE, OR THIS DAY'S SUPPLY." and 858 – "PHYSICAL MEDICINE AND REHABILITATION SERVICES MAY NOT BE REPORTED IN CONJUNCTION WITH AN E/M CODE PERFORMED ON THE SAME DAY." 28 Texas Administrative Code §134.202 requires that system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided. Per Medicare policy, procedure code 99213 is unbundled. This procedure is a component service of procedure code 98940 performed on the same date. Payment for this service is included in the payment for other services performed. Separate payment is not recommended.

- Procedure code 99213, service date January 24, 2006, was denied with reason codes 42 – "CHARGES EXCEED OUR FEE SCHEDULE OR MAXIMUM ALLOWABLE AMOUNT." and 790 – "THIS CHARGE WAS REDUCED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE." No documentation was found to support a contractual fee agreement applicable to the services in dispute. Reimbursement is calculated according to 28 Texas Administrative Code §134.202(c), effective January 5, 2003, 27 *Texas Register* 4048 and 12304 "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%." The 2006 Medicare payment rate for procedure code 99213 performed in Dallas, Texas is \$54.60. This amount multiplied by 125% is \$68.25.
- Procedure code 97750-FC, service date March 14, 2006, was denied with reason codes 97 – "PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE." and 435 – "PER NCCI EDITS, THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF THE COMPREHENSIVE PROCEDURE." The respondent's position statement asserts that "Texas Mutual denied payment of this code billed 3/14/06 because the requester also billed code 96004. Review of the CCI Edits shows code 97750 is a component code of 96004. As such no payment was issued." Per 28 Texas Administrative Code §134.202(c), "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: . . . (5) for commission specific codes, services and programs (e.g., Functional Capacity Evaluation, Impairment Rating Evaluations, Return to Work Programs, etc.) as calculated in accordance with subsection (e) of this section." Subsection 134.202(e) requires that "Payment policies relating to coding, billing, and reporting for commission-specific codes, services, and programs are as follows: (1) Billing. Health care providers (HCPs) shall bill their usual and customary charges. HCPs shall submit medical bills in accordance with subsection (b), the Act, and commission rules." Subsection 134.202(e)(4) further requires that "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)." And lastly, Subsection 134.202(b) requires that "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." Per Medicare payment policy, as found in the National Correct Coding Initiative edits, procedure code 97750 may not be reported with procedure code 96004, performed on the same date of service. The insurance carrier's denial reasons are supported. Separate payment is not recommended.
- Procedure code 99213, service date March 23, 2006, was denied with reason codes 97 – "PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE." and 435 – "PER NCCI EDITS, THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF THE COMPREHENSIVE PROCEDURE." 28 Texas Administrative Code §134.202 requires that system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided. Per Medicare policy, procedure code 99213 is unbundled. This procedure is a component service of procedure code 99455 performed on the same date. Payment for this service is included in the payment for other services performed. Separate payment is not recommended.
- Procedure code 96004, service date April 28, 2006, was denied with reason codes 97 – "PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE." and 217 – "THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE." CPT code 96004 is defined as physician review and interpretation of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report. Motion analysis is performed in a dedicated motion analysis laboratory (ie, a facility capable of performing videotaping from the front, back and both sides, computerized 3-D kinematics, 3-D kinetics, and dynamic electromyography). Review of the clinical notes submitted by the requestor finds that the tests reviewed by the physician were not performed in a dedicated motion analysis laboratory and did not meet the description of the required tests as set out in the code's definition. The submitted documentation does not support the service as billed; therefore, payment cannot be recommended.

- Procedure code 97750-FC, service date May 22, 2006, was denied with reason codes 42 – "CHARGES EXCEED OUR FEE SCHEDULE OR MAXIMUM ALLOWABLE AMOUNT." and 281 – "FUNCTIONAL CAPACITY EVALUATIONS ARE ALLOWED A MAXIMUM OF FOUR HOURS-FOR AN INITIAL OR THREE TIMES FOR EACH INJURED WORKER." §134.202(e)(4) states that "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." The respondent submitted documentation to support that three prior functional capacity evaluations had been previously billed for this same injury; however, one of the prior FCE's, performed on March 8, 2006, was billed by a separate health care provider from the requestor in this dispute. No documentation was found to support that the requestor billed more than three FCE's for the compensable injury; therefore, the Division finds that the healthcare provider did not exceed the FCE billing limit as found in §134.202(e)(4). Nor was any documentation found to support that the insurance carrier has reimbursed the maximum of three FCEs in accordance with §134.202(e)(4). To the contrary, the documentation supports that the insurance carrier previously denied payment for the prior billed FCE, dated March 14, 2006 (as noted above). The respondent's position statement explains that "Texas Mutual denied payment of this code billed 3/14/06 because the requestor also billed code 96004. Review of the CCI Edits shows code 97750 is a component code of 96004. As such no payment was issued." As the insurance carrier has not yet issued payment for three total FCEs, the Division finds that the insurance carrier has not previously reimbursed the maximum number of FCEs for the compensable injury. Accordingly, the Division concludes that the insurance carrier's denial reasons for the discharge FCE performed on May 22, 2006, are not supported. Reimbursement is calculated as follows: The documentation supports that the FCE was a discharge test (and not an initial test); therefore, reimbursement shall be for up to a maximum of three hours. The provider billed three hours (12 units). The documentation supports 12 units. The 2006 Medicare payment rate for procedure code 97750, performed in Tarrant County, is \$29.85. This amount multiplied by 12 units is \$358.20. This amount multiplied by 125% is \$447.75.

6. The total recommended reimbursement is \$516.00. The insurance carrier has paid \$47.90, leaving a balance due to the requestor of \$468.10.

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 \$468.10.

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 \$468.10 plus applicable accrued interest per 28 Texas Administrative Code §134.803, and/or §134.130 if applicable, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Grayson Richardson
Medical Fee Dispute Resolution Officer

June 13, 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.