



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

RAMESH SADEGHIAN, DC

Respondent Name

AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number

M4-13-1561-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

FEBRUARY 21, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Never received an Explanation of Benefits. I have tried on several occasions to try to obtain claim status on the above date of service for an FCE with 8 units with charges of \$616.00. The claim was mailed to Gallagher Bassett Insurance – P.O. Box 23812 –Tucson, AZ 85734, the adjuster for the claim is Annie Pritchard, I have tried to speak with her regarding this claim and she will answer the line and quickly transfer me to a voice mail for her Assistant Dee Baker which has never returned my calls. I had a conversation with Annie Pritchard on 02/13/13 which resulted in a very rude display of unprofessionalism on her behalf, I asked her to tell me the status on why the claim has not been paid she yelled stating she has to transfer me to her Assistant and she could not help me, I stated that if the claim had been denied or rejected for any reason why can't she assist me I asked if she was the Adjuster for this file she said she was but still said she can't help me...she began to yell then hung up. I called back and left a very detailed message for her to send me a conclusion letter and I never received a return call or fax ."

Amount in Dispute: \$616.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This is a network claim. A chiropractor cannot be the treating physician. **There is an extent issue that may relate to the treatment in dispute.**"

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 29, 2012	CPT Code 97750-FC (8 units) Functional Capacity Evaluation (FCE)	\$616.00	\$418.16

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

- 28 Texas Administrative Code §133.307, effective June 1, 2012, sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.240, effective May 2, 2006, sets out the procedure for medical bill processing by insurance carriers.

3. 28 Texas Administrative Code §133.10 sets out the billing procedures for health care providers.
4. 28 Texas Administrative Code §134.204 and §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 125-Submission billing error(s).

Issues

1. Does this dispute involve a network claim?
2. Does an extent of injury issue exist in this dispute?
3. Did the provider bill for the disputed service in accordance with 28 Texas Administrative Code §133.10?
4. Is the requestor entitled to reimbursement for the FCE rendered on February 29, 2012?

Findings

1. The respondent states in the position summary that “This is a network claim.”

Based upon Division records, the claimant was in the Coventry Health Care Workers Compensation, Inc. network effective March 29, 2012. The disputed date of service is February 29, 2012. A review of the submitted documentation does not support that this was a network claim.

28 Texas Administrative Code §133.240(a) states “An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier’s deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.”

A review of the submitted explanation of benefits does not support that the disputed FCE was denied payment based upon it being a network claim.

Furthermore, 28 Texas Administrative Code §133.307(d)(2)(F) states in part “The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.”

A review of the submitted documentation and explanation of benefits does not support the issue of a network claim was raised prior to dispute resolution. Therefore, the network claim issue will not be considered further per 28 Texas Administrative Code §133.307(d)(2)(F).

2. The respondent states in the position summary that “**There is an extent issue that may relate to the treatment in dispute.**”

A review of the submitted documentation and explanation of benefits does not support the respondent raised the extent of injury issue regarding the disputed FCE prior to dispute resolution. Therefore, the extent of injury issue will not be considered further per 28 Texas Administrative Code §133.307(d)(2)(F).

3. According to the explanation of benefits, the respondent denied reimbursement for the FCE based upon reason code “125”.

A review of the submitted bill finds that the requestor completed and billed for the disputed service in accordance with 28 Texas Administrative Code §133.10. The Division finds that the respondent’s denial is not supported.

4. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204.

On the disputed date of service, the requestor billed CPT code 97750-FC.

The American Medical Association (AMA) Current Procedural Terminology (CPT) defines CPT code 97750 as “Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes.”

The requestor appended modifier “FC” to code 97750. 28 Texas Administrative Code §134.204(n)(3) states “The following Division Modifiers shall be used by HCPs billing professional medical services for correct

coding, reporting, billing, and reimbursement of the procedure codes. (3) FC, Functional Capacity-This modifier shall be added to CPT Code 97750 when a functional capacity evaluation is performed”.

28 Texas Administrative Code §134.204(g) states "The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division 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."

A review of the submitted medical bill indicates that the requestor billed for eight units, which equals two hours; therefore, the requestor did not exceed the time limit set in 28 Texas Administrative Code §134.204(g).

Per 28 Texas Administrative Code §134.204(g) to determine the reimbursement for FCEs the Division refers to 28 Texas Administrative Code §134.203(c)(1)(2).

Per 28 Texas Administrative Code §134.203(c)(1)(2), the following formula is used to calculate the Maximum Allowable Reimbursement (MAR): (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = MAR.

The 2012 DWC conversion factor for this service is 54.86.

The Medicare Conversion Factor is 34.0376.

Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 77015 which is located in Houston, Texas; therefore, the Medicare locality is "Houston, Texas."

The Medicare participating amount for CPT code 97750 is \$32.43.

Using the above formula, the MAR is \$52.27 per unit. The requestor billed for 8 units; therefore, \$52.27 X 8 = \$418.16. The respondent paid \$0.00. The difference between MAR and amount paid is \$418.16; this amount is recommended for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$418.16.

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 \$418.16 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

05/06/2015
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).

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