



**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](http://www.tdi.texas.gov)

**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**GENERAL INFORMATION**

**Requestor Name**

MARCUS P. HAYES, DC

**Respondent Name**

ARCH INSURANCE CO

**MFDR Tracking Number**

M4-14-0676-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

OCTOBER 28, 2013

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "I submitted a properly completed, properly documented claim to Gallagher Bassett. Payment was denied due to: 219 Extent of Injury. A request for reconsideration was then submitted noting that there is no extent of issue. The IC responded by again denying payment due to: 45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement...[Claimant's] initial FCE was performed 01/25/2012. The second FCE performed was performed on 02/15/2012 and the third/final FCE was performed on 04/17/2013."

**Amount in Dispute:** \$617.28

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary dated November 8, 2013:** "...have forwarded this matter to our bill review department for an additional review. Once we have the results of this additional review, we will supplement a response with our position."

**Respondent's Position Summary dated November 15, 2013:** "Coventry reconsidered this bill and determined the bill review reductions applied appropriately...It is our position that no further monies are due."

**Response Submitted By:** Gallagher Bassett Services, Inc.

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 17, 2013	CPT Code 97750-FC (12 units) Functional Capacity Evaluation (FCE)	\$617.28	\$617.28

**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 medical fee disputes.
2. 28 Texas Administrative Code §133.240, effective July 1, 2012, sets out the procedure for medical bill processing by insurance carriers.

3. 28 Texas Administrative Code §134.204 and §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 219-Based on extent of injury.
  - 45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

### **Issues**

1. Does an extent of injury issue exist in this dispute?
2. Does a contractual agreement issue exist in this dispute?
3. Is the requestor entitled to additional reimbursement for the FCE rendered on April 17, 2013?

### **Findings**

1. According to the explanation of benefits, the carrier denied payment for the services in dispute based upon reason code "219."

28 Texas Administrative Code §133.240(f)(17)(H) states "explanation of the reason for reduction/denial if the adjustment reason code was included under subparagraph (G) of this paragraph and if applicable."

The requestor wrote the respondent on July 20, 2013 "Regarding denial code '219', the accepted compensable injury is the right shoulder. This claim was billed, and the report was based on , a right shoulder injury. Additionally, all previous claim submissions before and after the 04/17/2013 claim was paid with the same diagnosis code."

28 Texas Administrative Code §133.250(f)(1) states "The insurance carrier shall take final action on a reconsideration request within 30 days of receiving the request for reconsideration. The insurance carrier shall provide an explanation of benefits: (1) in accordance with §133.240(e) - (f) of this title (relating to Medical Payments and Denials) for all items included in a reconsideration request in the form and format prescribed by the division when there is a change in the original, final action."

A review of the reconsideration explanation of benefits finds there was a change in the original, final action. The Division finds that based upon the submitted documentation an extent of injury issue does not exist in this file.

2. According to the explanation of benefits, the carrier paid the services in dispute in accordance with a contracted or legislated fee arrangement. The "PPO REDUCTIONS" amount on the submitted explanation of benefits denotes a discount was not taken. The Division finds that documentation does not support that the services were discounted due to a contract; therefore, reimbursement for the services will be reviewed in accordance with applicable Division rules and guidelines.
3. 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."

The requestor states in the position summary that the disputed FCE was the discharge test. A review of the submitted medical bill indicates that the requestor billed for twelve units, which equals three hours; therefore, the requestor did not exceed the three hour 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 2013 DWC conversion factor for this service is 55.3.

The Medicare Conversion Factor is 34.023.

Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 78229 which is located in San Antonio, Texas; therefore, the Medicare locality is "Rest of Texas."

The Medicare participating amount for CPT code 97750 is \$31.65.

Using the above formula, the MAR is \$51.44 per unit. The requestor billed for 12 units; therefore, \$51.44 X 12 = \$617.28. The respondent paid \$0.00. The difference between MAR and amount paid is \$617.28; this amount is recommended for additional reimbursement.

**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 \$617.28.

**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 \$617.28 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.**