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

ERIC A VANDERWERFF DC
615 N OCONNOR ROAD 12
IRVING TX 75061

Respondent Name

LIBERTY INSURANCE CORP

MFDR Tracking Number

M4-14-1277-01

Carrier's Austin Representative Box

Box Number 01

MFDR Date Received

JANUARY 7, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "**CHRONIC PAIN MANAGEMENT SERVICE ON 2/12/13 IS PRE-AUTHORIZED AND SHOULD BE PAID IN FULL. FUNCTIONAL CAPACITY EVALUATION TEST DONE ON 1/18/13 IS REQUIRED, PER ODG, WHILE THE PATIENT IS PERFORMING CPM AND SHOULD BE PAID**."

Amount in Dispute: $1,579.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated January 24, 2014: "Attached are copies of the preauthorization letters and the EOBS showing reimbursement for the 30 preauthorized visits of chronic pain management billed with 97799. The final and 31st visit was denied as not preauthorized. Medical Fee Guidelines specify the number of FCE's allowed per injury. Attached are the EOBs reflecting our payment for the three required visits and denial of a 4th FCE."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 18, 2013	CPT Code 97750-FC (16 units) Functional Capacity Evaluation	$779.20	$655.35
February 12, 2013	CPT Code 97799-CP (8 units) Chronic Pain Management	$800.00	$800.00
TOTAL		$1,579.20	$1,455.36

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 §134.204 and §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- X170-Pre-authorization was required, but not requested for this service per DWC Rule 134.600.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- Z989-The amount paid previously was less than is due. The current recommended amount is the result of supplemental payment.
- 206-The service(s) is for a condition(s) which is not related to the covered work related injury. For reconsideration of charges, please submit appeal with EOP and documentation to support the relatedness of services rendered to the work related injury.
- X435-Based on peer review, further treatment is not recommended.

Issues

1. Is the requestor entitled to reimbursement for the functional capacity evaluation rendered on January 18, 2013?
2. Does a compensability/relatedness issue exist in this dispute regarding the chronic pain management services rendered on February 12, 2013?
3. Does a preauthorization issue exist?
4. Is the requestor entitled to reimbursement for chronic pain management services rendered on February 12, 2013?

Findings

1. 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.”

   CPT code 97750 is defined as “Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes.”

   A review of the submitted documentation finds that the requestor billed for CPT code 97750-FC on November 16, 2012, December 19, 2012, January 18, 2013, and February 14, 2013. Per 28 Texas Administrative Code §134.204 (g), the disputed January 18, 2013 FCE was the discharge test.

   Per 28 Texas Administrative Code §134.203(c)(1)(2), “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. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (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. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007.”

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (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 the services were rendered in zip code 75061 in Irving, Texas. Per Medicare the provider is reimbursed using the locality of Dallas, Texas.

   The Medicare Participating amount for code 97750 is $33.60/15 minutes.

Using the above formula, the Division finds the following:

DATE	TEST	No. of Units Billed	No. of Units Allowed per 28 Texas Administrative Code §134.204 (g)	TOTAL MAR	TOTAL PAID	AMOUNT DUE
1/18/2013	97750-FC	16	12 for Discharge Test	$655.35	$0.00	$655.35

2. According to the submitted explanations of benefits, the insurance carrier initially denied reimbursement for the chronic pain management based upon reason code "206-The service(s) is for a condition(s) which is not related to the covered work related injury. For reconsideration of charges, please submit appeal with EOP and documentation to support the relatedness of services rendered to the work related injury." Review of the submitted information found upon reconsideration, the respondent did not maintain this denial. For this reason, the disputed services will be reviewed in accordance with applicable Division fee guidelines.

3. The respondent also denied reimbursement for the chronic pain management rendered on February 12, 2013 based upon reason code "X170."

   The requestor contends that reimbursement is due because the services were preauthorized…"**that only 232 units have been paid even though a total of 240 units were requested (see attached), approved (see attached), and billed appropriately**. We are seeking payment for our final 8 units of preauthorized chronic pain management services for the date of service 2/12/13." In support of the position, the requestor submitted copies of preauthorization reports dated December 10, 2012, December 27, 2012, and January 23, 2013 that preauthorized 240 hours of chronic pain management.

   The respondent submitted EOBs that support the following:

DATE	No. of Units of Chronic Pain Management Billed and Paid
December 10, 2012	8
December 11, 2012	8
December 12, 2012	8
December 14, 2012	8
December 17, 2012	8
December 19, 2012	4
December 20, 2012	8
December 21, 2012	4
December 27, 2012	4
December 28, 2012	8
January 3, 2013	8
January 4, 2013	4
January 7, 2013	8
January 8, 2013	8
January 9, 2013	8
January 10, 2013	8
January 11, 2013	8
DATE	No. of Units of Chronic Pain Management Billed and

	Paid
January 17, 2013	8
January 22, 2013	8
January 24, 2013	8
January 25, 2013	8
January 28, 2013	8
January 30, 2013	8
January 31, 2013	8
February 1, 2013	8
February 4, 2013	8
February 5, 2013	8
February 6, 2013	8
February 7, 2013	8
February 8, 2013	8
February 11, 2013	8
TOTAL	232 hours of Chronic Pain Management

Because preauthorization was granted for 240 hours of chronic pain management, the respondent's denial of the 8 hours of chronic pain management rendered on February 12, 2013 based upon "X170" is not supported. Reimbursement is recommended per Division fee guideline.

4. 28 Texas Administrative Code §134.204(h)(1)(B) states "If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

   28 Texas Administrative Code §134.204(h)(5)(A) and (B) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs

   (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

   (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

The Division finds that the requestor billed CPT code 97799-CP for eight (8) units on February 12, 2013. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(B) and (5)(A) and (B), the MAR for a non-CARF accredited program is $100.00 per hour ($125.00 X 80%). $100.00 times the eight hours billed is $800.00. The respondent paid $0.00. The difference between the MAR and amount paid is $800.00. 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 $1,455.36.

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 $1,455.36 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		03/17/2014
Signature	Medical Fee Dispute Resolution Officer	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.

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