



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

DR. ROBERT FRASER

Respondent Name

AMERICAN CASUALTY CO OF READING PA

MFDR Tracking Number

M4-14-1294-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

JANUARY 9, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This FCE was a DESIGNATED DOCTOR EXAM therefore 'FCEs requested by a Designated Doctor are NOT limited to a maximum of 3 or the reduction of units for a second or third FCE for Treating Doctors and are allowed to be reimbursed up the full 4 hours allowed'...Therefore, we should have received the total MAR submitted in the original claim for our services on 5/16/13."

Amount in Dispute: \$1,215.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 16, 2013	CPT Code 97750-FC (16 units) Functional Capacity Evaluation (FCE)	\$1,200.00	\$823.04
	CPT Code 99080-73 Work Status Report	\$15.00	\$15.00
TOTAL		\$1,215.00	\$838.04

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 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.204 and §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
- 28 Texas Administrative Code §127.10, effective September 1, 2012 sets out the provisions for Designated Doctor Examinations.

4. 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
5. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on January 17, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
 1. 197-No code description given.
 2. 50-These are non-covered services because this is not deemed a medical necessity by the payer.
 3. Workers compensation claim adjudicated as non-compensable. Carrier not liable for claim or service/treatment.
 4. Services not authorized need preauth.

Issues

1. Does a medical necessity/compensability/preauthorization issue exist in this dispute?
2. Is the requestor entitled to reimbursement for the FCE rendered on May 16, 2013?
3. Is the requestor entitled to reimbursement for the work status report rendered on May 16, 2013?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the disputed FCE based upon reason code "50," Workers compensation claim adjudicated as non-compensable," and "Services not authorized need preauth."

28 Texas Administrative Code §127.10(c) states in part "The designated doctor shall perform additional testing when necessary to resolve the issue in question. The designated doctor shall also refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question and the designated doctor is not qualified to fully resolve the issue in question. Any additional testing or referral required for the evaluation is not subject to preauthorization requirements nor shall those services be denied retrospectively based on medical necessity, extent of injury, or compensability in accordance with the Labor Code §408.027 and §413.014, Insurance Code Chapter 1305, or Chapters 10, 19, 133, or 134 of this title (relating to Workers' Compensation Health Care Networks, Agents' Licensing, General Medical Provisions, and Benefits-- Guidelines for Medical Services, Charges, and Payments, respectively) but is subject to the requirements of §180.24 of this title (relating to Financial Disclosure)."

The requestor states "This FCE was a DESIGNATED DOCTOR EXAM"; therefore, per 28 Texas Administrative Code §127.10(c), the respondent's denial of reimbursement based upon not medically necessary, non-compensable, and preauthorization not obtained are not supported.

2. 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 performed by the Designated Doctor. A review of the submitted medical bill indicates that the requestor billed for sixteen units, which equals four hours; therefore, the requestor did not exceed the four hour limit set in 28 Texas Administrative Code §134.204(g) for Division ordered FCEs.

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 78410 which is located in Corpus Christi, Texas; therefore, the Medicare locality is “Rest of Texas.”

The Medicare participating amount for CPT code 97750 is \$33.44.

Using the above formula, the MAR is \$51.44 per unit. The requestor billed for 16 units; therefore, \$51.44 X 16 = \$823.04. The respondent paid \$0.00. The difference between MAR and amount paid is \$823.04; this amount is recommended for additional reimbursement.

3. CPT code 99080-73 is defined as “Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form.”

28 Texas Administrative Code §127.10(e) states in part “A designated doctor who examines an injured employee pursuant to any question relating to return to work is required to file a Work Status Report that meets the required elements of these reports described in §129.5 of this title (relating to Work Status Reports) and a narrative report that complies with the requirements of §127.220(a) of this title within seven working days of the date of the examination of the injured employee.”

28 Texas Administrative Code §129.5(i)(1) states “Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be \$15. A doctor shall not bill in excess of \$15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section.”

Based on 28 Texas Administrative Code §127.10(e) and §129.5(i)(1), the requestor is due \$15.00 for the work status report.

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 \$838.04.

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 \$838.04 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

04/17/2015
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.