Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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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
INDEMNITY INSURANCE CO OF NORTH AMERICA

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-14-1495-01

MFDR Date Received
JANUARY 27, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Functional Capacity Evaluation (FCE) performed on 4/30/13, which has been denied, is actually REQUIRED, according to the ODG guidelines…the ODG requires us to re-evaluate our Chronic Pain Management patients every two weeks while they are in the program. An FCE is the standard method of objective re-evaluation, since this program is also known as a multi-disciplinary functional restoration program. We cannot measure function any other way, besides a Functional Capacity Evaluation. **We are exempt from the limitation of 3 FCEs per compensable injury, because these FCEs that we are REQUIRED to perform, as per the ODG (which is required by the DWC's Rules) are exempted by §134.202...Furthermore, because these FCEs were performed as required by the ODG, and because we are ordered by the Division to follow the ODG in Rule §137.100, all of our FCEs are allowed to last for up to four hours per test**…The fact that the patient cannot continue in the program without the follow-up FCE on **4/03/13** demonstrates the medical necessity' of that evaluation. And, of course, not to mention, the fact that ESIS APPROVED the patient's continuation in the Chronic Pain Program, based almost exclusively upon the data provided by the follow-up FCE, which again, was required per the ODG in order to assess the patient's progress. **This evaluation is necessary, REQUIRED, and should be paid accordingly**. "

Amount in Dispute: $779.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "ESIS Med Bill Impact's Bill Review Department reviewed the above mentioned date of service and found that the provider was not due additional money. It has been determined that ESIS Med Bill Impact will stand on the original recommendation of $0.00. Per the claims adjuster, this testing was not approved."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 3, 2013	CPT Code 97750-FC (16 units) Functional Capacity Evaluation	$779.20	$779.20

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
   - 150-PT time parameters or fee schedule allowance exceeded.
   - CIQ378-This appeal is denied as we find the original review reflected the appropriate allowance for the service rendered. We find that no additional recommendation is warranted at this time.
   - 150, ANSIW1, ANSI119, RE555-Previous recommended history on DCN(s): 8675228=$0.00.
   - 119-Benefit maximum for this time period or occurrence has been reached.
   - Previous recommended payment amount on line: $0.
   - W1-Workers compensation jurisdiction fee schedule adjustment.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to reimbursement for the functional capacity evaluation rendered on April 3, 2013?

Findings

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.”

According to the submitted explanation of benefits, the disputed FCE was denied payment because the testing exceeded the number of test or time allowed at 28 Texas Administrative Code §134.204 (g).

On February 19, 2014 and March 5, 2014, the Division attempted to contact the respondent’s representative, Kristine Olmsted, to verify the number of FCEs performed prior to the disputed date of service. At the time of review, the respondent’s representative failed to provide the requested information. The Division finds that based upon the submitted documentation the denial reason of “150 and 119” is not supported.

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

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 75061in 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 MAR is $873.80. The requestor is seeking dispute resolution for a lesser amount of $779.20. The respondent paid $0.00. As a result, the Division finds the requestor is due $779.20.

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 $779.20.

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 $779.20 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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