



# 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**

ERIC A VANDERWERFF DC

**Respondent Name**

FEDEX GROUND PACKAGE SYSTEM INC

**MFDR Tracking Number**

M4-14-2044-01

**Carrier's Austin Representative**

Box Number 22

**MFDR Date Received**

MARCH 10, 2014

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "First, according to the TWCC Advisory 96-17 (see attached), manipulations (98941) are NOT considered a part of physical or occupational therapy, and therefore do not require preauthorization...Secondly, the Functional Capacity Evaluations (FCE) which have been denied by the carrier, are actually REQUIRED, according to the ODG guidelines."

**Amount in Dispute:** \$2,398.60

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary Dated March 25, 2014:** "Because the billing does not reflect the correct number of spinal regions, no additional reimbursement is due at this time."

**Response Submitted by:** Broadspire

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 4, 2013 through May 30, 2013	CPT Code 98941 (X15 Dates) Chiropractic manipulative treatment (CMT); spinal, 3-4 regions	\$69.00 X 15 = \$1,035.00	\$817.60
June 21, 2013	CPT Code 97750-FC (14 units) Functional Capacity Evaluation	\$681.80	\$436.90
August 7, 2013	CPT Code 97750-FC (14 units) Functional Capacity Evaluation	\$681.80	\$655.35
TOTAL		\$2,398.60	\$1,909.85

#### 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.

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
  - 45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
  - W1-Workers' compensation jurisdictional fee schedule adjustment.
  - 16-Claim/service lacks information which is needed for adjudication.
  - 18-Duplicate claim/service.
  - 7-The procedure/revenue code is inconsistent with the patient's gender.
  - 887-003-Time required for processing.

**Issues**

1. Does a contractual agreement issue exist in this dispute?
2. Does the documentation support billing of CPT code 98941? Is the requestor due reimbursement?
3. Is the requestor entitled to reimbursement for the functional capacity evaluation rendered on June 21, 2013 and August 7, 2013?

**Findings**

1. According to the submitted explanations of benefits, the insurance carrier reduced or denied disputed services with reason code "45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement ." Review of the submitted information found no documentation to support that the disputed services were subject to a contractual agreement between the parties to this dispute. The respondent has not supported the above denial/reduction explanation. For this reason, the disputed services will be reviewed for payment in accordance with applicable Division fee guidelines
2. CPT Code 98941 is defined as "Chiropractic manipulative treatment (CMT); spinal, 3-4 regions."
  - The requestor billed 15 units of CPT code 98941 from April 4, 2013 through May 30, 2013.
  - The respondent denied reimbursement based upon reason code "16."
  - The five regions of the spine are: Cervical, Thoracic, Lumbar, Pelvic (Sacro-Iliac), and Sacral.
  - A review of the requestor's progress notes indicates that the requestor adjusted/manipulated the Thoracic, Lumbar, Ilium and Sacrum or a combination of 3 or 4 of these region on 14 of the 15 dates. The requestor did not support manipulation of 3 regions on May 20, 2013; therefore, the requestor is due reimbursement for fourteen dates of CPT code 98941.
  - 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 98941 is \$35.93.

- Using the above formula the MAR is \$58.40/day. This amount multiplied by 14 days equals \$ 817.60. The respondent paid \$0.00; therefore, the requestor is due \$817.60.
3. CPT code 97750 is defined as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes."
- The respondent denied reimbursement for the FCEs based upon reason codes "7," and "887-003."
  - 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."
  - Based upon the submitted documentation the requestor performed FCEs on March 5, 2013, June 21, 2013 and August 7, 2013.
  - 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
6/21/2013	97750-FC	14	8 for Interim Test	\$436.90	\$0.00	\$436.90
8/7/2013	97750-FC	14	12 for Discharge Test	\$655.35	\$0.00	\$655.35

**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 \$1,909.85.

***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 \$1,909.85 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

04/11/2014  
\_\_\_\_\_  
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.**