



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

MILLENIUM CHIROPRACTIC

Respondent Name

TWIN CITY FIRE INSURANCE CO

MFDR Tracking Number

M4-15-0215-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

SEPTEMBER 15, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is our position that the Functional Capacity Evaluation(s) (FCEs) performed on **1/17/14 and 4/29/14** which the carrier denied based on **denial codes (309) and (600)**, are actually REQUIRED, according to the ODG guidelines. Rule §137.100 REQUIRES us to treat our patients according to the provisions of the ODG... This means that 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 multi-disciplinary functional restoration program. We cannot measure function any other way besides an FCE, AND THE CARRIER WILL NEVER, EVER, EVER, PRE-AUTHORIZE ADDTIIONAL TREATMENT IN THE CPM PROGRAM WITHOUT A FOLLOW-UP FCE. WE DO NOT DO THE FCE's FREE OF CHARGE, NOR ARE WE REQUIRED TO DO SO. **Additionally, we are exempt from the limitation of 3 FCEs per compensable injury, because these are FCEs that we are REQUIRED to perform, as per the ODG.**"

Amount in Dispute: \$473.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our review shows that an overpayment has been made.

- The Provider billed for dos 1/16/14 (16 units), dos 2/28/14 (14 units), dos 4/2/14 (14 units) and dos 5/12/14 (16 units). Total reimbursement \$2743.52, which resulted in an overpayment of \$844.16 for dos 5/12/14.
- Additional reimbursement is not recommended."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 28, 2014	CPT Code 97750-FC (12 units) Functional Capacity Evaluation	\$342.46	\$0.00
April 2, 2014	CPT Code 97750-FC (14 units) Functional Capacity Evaluation	\$131.42	\$0.00
TOTAL		\$473.88	\$0.00

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

- W1-Workers compensation state fee schedule adjustment.
- 309-The charge for this procedure exceeds the fee schedule allowance.
- 600-Allowance based on maximum number of units allowed per fee schedule guidelines and/or service code description.
- W3-Additional payment made on appeal/reconsideration.
- 193-Original payment decision is being maintained. This claim was processed properly the first time.
- 1115-We find the original review to be accurate and are unable to recommend any additional allowance.

Issues

Is the requestor entitled to reimbursement for the functional capacity evaluations rendered on February 28, 2014 and April 2, 2014?

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."

Based upon the respondent's position, the claimant had an initial FCE performed on January 16, 2014; therefore, the disputed services are the interim and discharge FCE.

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 2014 DWC conversion factor for this service is 55.75.

The Medicare Conversion Factor is 35.8228

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 \$33.90/15 minutes.

Using the above formula, the Division finds the following:

Date	Rule 134.204(g)	MAR	Total Paid	Total Due
February 28, 2014 – Interim FCE	Maximum number of units allowed for interim FCE is 8 units	\$422.06	\$422.08	\$0.00
April 2, 2014 – Discharge FCE	Maximum number of units allowed for discharge FCE is 12	\$633.09	\$633.12	\$0.00

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

Date

10/20/2014

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.