



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

LIBERTY INSURANCE CORP

MFDR Tracking Number

M4-15-0325-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

SEPTEMBER 22, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is our position that the Functional Capacity Evaluation(s) (FCEs) performed on 5/7/14 and 6/5/14 which the carrier denied based on denial code (M359), 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 ADDITIONAL 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: \$1,747.52

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have attached copies of all of the EOBs showing the FCE's completed on this claim for [Claimant]. Evaluations were completed on 10/8/13, 12/17/13, 2/18/14, 3/21/14, 5/7/14, 6/5/14 and 8/1/14...The initial FCE paid on this claim was for 10/8/2013, the second was 12/17/2013. The FCE on 2/18/14 was ordered by a DDE and did not count toward the limitations. The third payable FCE was on 3/21/14."

Response Submitted by: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 7, 2014	CPT Code 97750-FC (16 units) Functional Capacity Evaluation	\$873.76	\$0.00
June 5, 2014	CPT Code 97750-FC (16 units) Functional Capacity Evaluation	\$873.76	\$0.00
TOTAL		\$1,747.52	\$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
 - M359-Time expended on or the number of Functional Capacity Evaluations has been exceeded.
 - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - X598-Claim has been re-evaluated based on additional documentation submitted, no additional payment due.

Issues

Is the requestor entitled to reimbursement for the functional capacity evaluations rendered on May 7, 2014 and June 5, 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, "Evaluations were completed on 10/8/13, 12/17/13, 2/18/14, 3/21/14, 5/7/14, 6/5/14 and 8/1/14...The initial FCE paid on this claim was for 10/8/2013, the second was 12/17/2013. The FCE on 2/18/14 was ordered by a DDE and did not count toward the limitations. The third payable FCE was on 3/21/14."

Based upon the submitted documentation, the requestor has performed seven FCEs on the claimant. The respondent paid for four evaluations and denied the fifth and sixth FCEs based upon reason code "M359." No documentation was submitted to support that the disputed FCEs rendered on May 7, 2014 and June 5, 2014 were ordered by the Division; therefore, the limit of three FCEs outlined in 28 Texas Administrative Code §134.204(g) applies. The Division finds that the requestor exceeded the number of FCEs allowed in 28 Texas Administrative Code §134.204(g). The respondent's denial based upon "M359" is supported. No reimbursement can be recommended.

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

Elizabeth Pickle, RHIA
Medical Fee Dispute Resolution Officer

10/20/2014
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.

