



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

ANDREA SMITH, DC

Respondent Name

LIBERTY INSURANCE CORP

MFDR Tracking Number

M4-15-2330-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

MARCH 27, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to Hartford Insurance on January 22, 2015, this request was in response to a \$799.04 reduction of the \$846.24 for the FCE Designated Doctor Referred Exam performed on November 12, 2014. Unfortunately our request was denied and we are seeking the balance owed to us."

Amount in Dispute: \$46.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The FCE for [Claimant] on January 8, 2015 was reimbursed at \$50 per unit X 16 units + \$800.00."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 8, 2015	CPT Code 97750-FC (16 units) Functional Capacity Evaluation (FCE)	\$46.24	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.
 - Z710-The charge for this procedure exceeds the fee schedule allowance.

- P300-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3-Additional payment made on appeal/reconsideration.
- X598-Claim has been re-evaluated based on additional documentation submitted; no additional payment due.
- Z951-Additional allowance not recommended per fee schedule, usual and customary guidelines and-or provider's PPO contract.

Issues

Is the requestor entitled to additional reimbursement for the FCE rendered on January 8, 2015?

Findings

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 part of a Designated Doctor Referred Exam. A review of the submitted medical bill indicates that the requestor billed for fourteen units, which equals three and a half 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 2015 DWC conversion factor for this service is 56.2.

The Medicare Conversion Factor is 35.7547.

Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 77489 which is located in Missouri City, Texas; therefore, the Medicare locality is "Rest of Texas."

The Medicare participating amount for CPT code 97750 is \$31.81.

Using the above formula, the MAR is \$50.00 per unit. The requestor billed for 16 units; therefore, \$50.00 X 16 = \$800.00. The respondent paid \$800.00. The difference between MAR and amount paid is \$0.00. As a result, additional reimbursement is not 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

		05/27/2015
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, 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 MFDR 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.