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
CYNTHIA L. TAYS, DC

Respondent Name
TRUCK INSURANCE EXCHANGE

MFDR Tracking Number
M4-15-2519-01

Carrier's Austin Representative
Box Number 14

MFDR Date Received
APRIL 13, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to Truck Insurance Exchange on August 6, 2014, this request was in response to a nonpayment of the $947.20 for the FCE Designated Doctor Referred Exam performed on April 15, 2014. Unfortunately our request was denied and we are seeking the balance owed to us."

Amount in Dispute: $947.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Since the DD that referred the patient to a non-network provider was not ordered by DWC to resolve a return to work dispute CorVel is maintaining the FCE performed on 04/15/14 exceeds DWC guidelines outlined under the general procedure rules for designated doctor examinations and the certified network based on DWC's Amended Order for DD Examination dated 2/25/14, the designated doctor's report dated 04/09/14 and the FCE report dated 04/15/14."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 15, 2014	CPT Code 97750-FC (16 units) Functional Capacity Evaluation (FCE)	$947.20	$837.92

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

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. 28 Texas Administrative Code §127.10, effective September 1, 2012 sets out the procedures for designated doctor examinations.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 196-Non network provider.
   - B5-Pymnt Adj/Program guidelines not met or exceeded.
   - W3-Appeal/Reconsideration.

Issues

1. Does a network issue exist in this dispute?
2. Is the requestor entitled to additional reimbursement for the FCE rendered on April 15, 2014?

Findings

1. According to the submitted explanation of benefits, the respondent denied reimbursement for the disputed FCE based upon reason code "196."

   The respondent states that "Since the DD that referred the patient to a non-network provider was not ordered by DWC to resolve a return to work dispute CorVel is maintaining the FCE performed on 04/15/14 exceeds DWC guidelines outlined under the general procedure rules for designated doctor examinations and the certified network based on DWC's Amended Order for DD Examination dated 2/25/14, the designated doctor's report dated 04/09/14 and the FCE report dated 04/15/14."

   28 Texas Administrative Code §127.10(c) states in part "The designated doctor shall perform additional testing when necessary to resolve the issue in question. The designated doctor shall also refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question and the designated doctor is not qualified to fully resolve the issue in question. Any additional testing or referral required for the evaluation is not subject to preauthorization requirements nor shall those services be denied retrospectively based on medical necessity, extent of injury, or compensability in accordance with the Labor Code §408.027 and §413.014, Insurance Code Chapter 1305, or Chapters 10, 19, 133, or 134 of this title (relating to Workers' Compensation Health Care Networks, Agents' Licensing, General Medical Provisions, and Benefits--Guidelines for Medical Services, Charges, and Payments, respectively) but is subject to the requirements of §180.24 of this title (relating to Financial Disclosure)."

   The requestor states "The FCE Designated Doctor Referred Exam"; therefore, per 28 Texas Administrative Code §127.10(c), the respondent's denial of reimbursement based on Insurance Code Chapter 1305 is not supported. As a result, reimbursement is recommended per the fee guideline.

2. 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 requested by the Designated Doctor. A review of the submitted medical bill indicates that the requestor billed for sixteen units, which equals four 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 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 finds that the services were rendered in zip code 78752 which is located in Austin, Texas; therefore, the Medicare locality is "Austin, Texas."

The Medicare participating amount for CPT code 97750 is $33.65.

Using the above formula, the MAR is $52.37 per unit. The requestor billed for 16 units; therefore, $52.37 X 16 = $837.92. The respondent paid $0.00. The difference between MAR and amount paid is $837.92. As a result, reimbursement of $837.92 is recommended.

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 $837.92.

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 $837.92 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	06/25/2015 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.