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
RAYMOND GLASS, DC

Respondent Name
TASB RISK MGMT FUND

MFDR Tracking Number
M4-15-2522-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
APRIL 13, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to TASB AUSTIN on August 6, 2014, this request was in response to a nonpayment of the $949.76 for the FCE Designated Doctor Referred Exam performed on April 12, 2014. Unfortunately our request was denied and we are seeking the balance owed to us."

Amount in Dispute: $949.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The original bill was received on August 6, 2014. The bill was appropriately denied, based on rule 133.20, for past the 95 day filing limit. Additionally, the provider didn't follow the following rules:

- Rule 133.307 requires a request for reconsideration to be submitted prior to filing a MDR. Dr. Glass did not follow regulatory requirements and submit a request for reconsideration for the above date of service.
- Additionally, a request for MDR shall be filed no later than one year after the date of service. The request for MDR was received on 4/21/15, past the one year filing deadline. The MDR filed with TDI-DWC does not comply with rule 133.07."

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 12, 2014	CPT Code 97750-FC (16 units) Functional Capacity Evaluation (FCE)	$949.76	$844.16

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 §133.250 sets out the guidelines for reconsideration of a medical bill.
4. Neither party to the dispute submitted explanation of benefits to support the denial of payment for the disputed services.

Issues

1. Did the requestor submit bill for reconsideration prior to requesting Medical Fee Dispute Resolution (MFDR)?
2. Did the respondent file response in accordance with 28 Texas Administrative Code §133.307?
3. Was the request for dispute resolution timely filed in accordance with 28 Texas Administrative Code §133.307?
4. Is the requestor entitled to reimbursement for the FCE rendered on April12, 2014?

Findings

1. The respondent asserts that "Rule 133.307 requires a request for reconsideration to be submitted prior to filing a MDR. Dr. Glass did not follow regulatory requirements and submit a request for reconsideration for the above date of service."

   28 Texas Administrative Code §133.250(i) states "If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills)."

   28 Texas Administrative Code §133.307(c)(2)(K) states "a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB."
   The requestor submitted the following copies as evidence of insurance carrier receipt of the bill and request for an EOB:

   - HCFA-1500 dated April 24, 2014.
   - Fax coversheet dated April 25, 2014 stamped "PROOF OF 1ST SUBMISSION" requesting payment and an EOB.
   - Fax coversheet dated August 6, 2014 stamped "SECOND SUBMISSION" requesting payment and an EOB.

   The Division finds that the request for medical fee dispute resolution was submitted in the form and manner required by 28 Texas Administrative Code §133.307(c)(2)(K).

2. The respondent filed a response to the request for MFDR and raises issues of 95 day timely filing.

   28 Texas Administrative Code §133.307 (d)(2)(F) states "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

   The respondent did not submit any explanation of benefits or documentation to support that the issue of 95 day timely filing was raised prior to the date the Division received the request for MFDR.

3. The respondent filed a response to the request for MFDR and raises issues of one year filing deadline.

   28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute."

The date of the services in dispute is April 12, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on Monday, April 13, 2014.

This date is later than one year after the date(s) of service in dispute.

28 Texas Administrative Code §102.3(a)(3) states "unless otherwise specified, if the last day of any period is not a working day, the period is extended to include the next day that is a working day." Because April 12, fell on a non-working day, the period is extended to include the next working day April 13, 2015.

The Division concludes that the requestor has timely filed this dispute with the Division's MFDR Section.

4. 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."

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 77042 which is located in Houston, Texas; therefore, the Medicare locality is "Houston, Texas."

The Medicare participating amount for CPT code 97750 is $33.90.

Using the above formula, the MAR is $52.76 per unit. The requestor billed for 16 units; therefore, $52.76 X 16 = $844.16. The respondent paid $0.00. The difference between MAR and amount paid is $844.16. As a result, additional reimbursement 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 $844.16.

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 $844.16 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.