



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

Jerrett H. Armstrong, D.C.

Respondent Name

New Hampshire Insurance Company

MFDR Tracking Number

M4-15-3565-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

June 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This request was in response to a \$40.00 reduction of the \$640.00 for the FCE performed on February 5, 2015."

Amount in Dispute: \$40.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Coventry is standing by the pricing."

Response Submitted by: Gallagher Bassett Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 5, 2015	Functional Capacity Evaluation (97750)	\$40.00	\$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 sets out the fee guidelines for Division-specific services.
- 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12 – Workers' compensation jurisdictional fee schedule adjustment
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.204 (g) states, in relevant part:

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)** [emphasis added] of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test ...

- 28 Texas Administrative Code §134.203 (c) states, in relevant part:

To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications...

(2) ... 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 Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. The Division conversion factor for 2015 is \$56.20.

For CPT code 97750 on February 5, 2015, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.000 is 0.450000. This procedure does not have the highest practice expense for this date. Using the multiple procedure payment reduction, the practice expense (PE) RVU of 0.46 multiplied by the PE GPCI of 0.920 is 0.423200. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.822 is 0.016440. The sum of 0.889640 is multiplied by the Division conversion factor of \$56.20 for a total of \$50.00. This total is multiplied by 16 units for a MAR of \$800.00.

2. The total MAR for the disputed services is \$800.00. The insurance carrier paid \$800.00. No further reimbursement is 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

Laurie Garnes
Medical Fee Dispute Resolution Officer

October 23, 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.