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
BRIAN MANN, DC

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-15-4035-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
AUGUST 13, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "A reconsideration was submitted on 5.26.15 showing proof that our office has only done 2 FCEs for the commission to reference."

Amount in Dispute: $741.91

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed an FCE for date 10/20/14, which is the fourth on claim …For that reason Texas Mutual declined to issue payment per Rule 134.204(g). The requestor billed a psychiatric diagnostic evaluation, code 90791, on 1/8/15. The evaluation including testing for depression…on 4/27/15 disputed depression as part of the injury….The requestor also billed a behavioral health assessment, code 96151, on 1/8/15. Texas Mutual declined to issue payment as this code is bundled to 90791 per NCCI Edits. No payment is due."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 20, 2014	CPT Code 97750-FC (8 units) Functional Capacity Evaluation (FCE)	$493.36	$0.00
January 8, 2015	CPT Code 90791 Psychiatric Diagnostic Evaluation	$214.68	$0.00
January 8, 2015	CPT Code 96151 Health and Behavior Assessment	$33.87	$0.00
TOTAL		$741.91	$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

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:
   - CAC-P12-Workers compensation jurisdictional fee schedule adjustment.
   - 738-FCE allowed a max of 3 times per injury (except DWC ordered) initial = max of 4 hrs; interim = max of 2 hrs; discharge = max of 3 hrs.
   - CAC-W3, 350-IN accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - CAC-193-Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly.
   - 891-No additional payment after reconsideration.
   - CAC-16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - CAC-219-Based on extent of injury.
   - 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - 246-The treatment/service has been determined to be unrelated to the extent of injury. Final adjudication has not taken place.
   - CAC-97-The benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated.
   - 217-The value of this procedure is included in the value of another procedure performed on this date.

Issues

1. Is the requestor entitled to reimbursement for the FCE rendered on October 20, 2014?
2. Did the medical fee dispute referenced above contain information/documentation that indicates that there are **unresolved** issues of Compensability, Extent of Injury and/or Liability (CEL)?
3. Are the disputed services, CPT codes 90791 and 96151, eligible for review by Medical Fee Dispute Resolution?

Findings

1. 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".

   The respondent denied reimbursement for CPT code 97750-FC based upon reason code "738." In support of their position, the respondent submitted copies of medical bills and explanation of benefits that support the claimant had FCEs performed on December 18, 2013, April 15, 2014, March 31, 2014 and October 20, 2014.

   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 submitted documentation, the claimant has undergone four FCEs. No documentation was submitted to support that any of the FCEs performed on the claimant were Division ordered; therefore, the disputed FCE performed on October 20, 2014 was the fourth one. Per 28 Texas Administrative Code §134.204(g), the October 20, 2014 FCE exceeded the limit of FCEs allowed per injury. As a result, no reimbursement is recommended.

2. According to the explanation of benefits, the respondent denied reimbursement for codes 90791 and 96151 based upon reason codes "219" and "246."

   Unresolved extent-of-injury dispute: The medical fee dispute referenced above contains unresolved issues of extent-of-injury for the same service(s) for which there is a medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical billing process.

   Dispute resolution sequence: 28 Texas Administrative Code §133.305(b) requires that extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(f) (3) (C) provides for dismissal of a medical fee dispute if the request for the medical fee dispute contains an unresolved extent of injury dispute for the claim. 28 Texas Administrative Code § 133.307(c) (2) (K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute.

   Extent-of-injury dispute process: The Division hereby notifies the requestor that the appropriate process to resolve the issue(s) of CEL, including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1.

3. The division finds that due to the unresolved extent of injury issues, the medical fee dispute request for codes 90791 and 96151 is not eligible for review until a final decision has been issued in accordance with 28 Texas Administrative Code §141.1.

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

		10/16/2015
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.