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
MILLENNIUM CHIROPRACTIC

Respondent Name
TWIN CITY FIRE INSURANCE CO

MFDR Tracking Number
M4-16-3617-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
AUGUST 5, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is our position that the Functional Capacity Evaluation(s) (FCEs) performed on **1/17/14 and 4/29/14** which the carrier denied based on **denial codes (296) and (P12)** are actually REQUIRED, according to the ODG guidelines…**There are no fee guidelines that support denial—as the ODG require these tests are part of the CPM parameters. As the FCEs are required, they should be paid in full—for the units/hours performed**."

Amount in Dispute: $4,914.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Denials of the Functional Capacity Exams were done so in accordance with Rule 134.402(e)(4)…The provider has submitted billing previously for FCEs and reimbursed (please see enclosed). Dates of service in dispute were not services included in part of the UR approval of that Chronic Pain Management Program and thus, denied."

Response Submitted By: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 4, 2015	CPT Code 97750-FC (16 units) Functional Capacity Evaluation (FCE)	$873.76	Untimely

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 21, 2015 October 6, 2015 January 11, 2016 January 26, 2016 February 16, 2016	CPT Code 97750-FC Functional Capacity Evaluation (FCE)	$4,041.14	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 §137.100, effective January 18, 2007, sets out the use of the treatment guidelines.
3. 28 Texas Administrative Code §134.204 and §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 296-Service exceeds maximum reimbursement guidelines.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 247-A payment or denial has already been recommended for this service.
   - B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - W3-Additional payment made on appeal/reconsideration.
   - P12-Paid average wholesale price plus dispensing fee.

Issues

1. Was the request for medical dispute resolution filed timely per 28 Texas Administrative Code §133.307?
2. Did requestor support position that the disputed services are in accordance with 28 Texas Administrative Code §137.100?
3. Is the requestor entitled to reimbursement for the functional capacity evaluation rendered on August 21, 2015, October 6, 2015, January 11, 2016, January 26, 2016 and February 16, 2016?

Findings

1. 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 dates of service in dispute are August 4, 2015 through February 16, 2016. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on August 5, 2015. This date is later than one year after the date(s) of service August 4, 2015. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section for date of service August 4, 2015; consequently, the requestor has waived the right to medical fee dispute resolution for date of service August 4, 2015.

2. Based upon the submitted explanation of benefits, the respondent denied reimbursement for code 97750-FC based upon reason codes "296-Service exceeds maximum reimbursement guidelines" and "P12-Workers' compensation jurisdictional fee schedule adjustment."

   The respondent states "The provider has submitted billing previously for FCEs and reimbursed (please see enclosed). Dates of service in dispute were not services included in part of the UR approval of that Chronic Pain Management Program and thus, denied." In support of their position, the respondent submitted explanation of benefits that indicate the requestor billed and was paid for code 97750-FC on January 16, 2014, February 28, 2014, April 2, 2014, June 12, 2014 and July 15, 2015.

   On the disputed dates 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.

   Because the requestor appended modifier "FC" to code 97750, the services in dispute are functional capacity evaluations.

   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 "**There are no fee guidelines that support denial—as the ODG require these tests are part of the CPM parameters. As the FCEs are required, they should be paid in full**."

   The ODG guidelines are addressed in 28 Texas Administrative Code §137.100. Review of the documentation submitted finds that the requestor failed to provide the portions of the ODG that relate to FCEs and chronic pain management to support their position that the service in dispute is "required" by the ODG. The Division concludes that the requestor's assertion regarding alleged requirement for FCEs is not supported. In addition, the requestor has not shown compliance with any applicable requirements in 28 Texas Administrative Code §137.100(f). For these reasons, 28 Texas Administrative Code §134.204(g) applies to the disputed service.

3. Based upon the submitted documentation, the requestor billed a total of eleven FCEs from January 16, 2014, to February 16, 2016. The respondent paid for five FCEs prior to August 4, 2015. The Division finds no documentation to support that the disputed FCEs were ordered by the division; therefore, no reimbursement is recommended for dates of service August 21, 2015 through February 16, 2016 per 28 Texas Administrative Code §134.204(g).

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 services in dispute.

Authorized Signature

		9/13/2016
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, effective May 31, 2012, *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 MDR 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.

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