TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
AMANDA MCINIS, DC

Respondent Name
AMGUARD INSURANCE CO

MFDR Tracking Number
M4-18-4009-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
JUNE 18, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is the position of this provider that the examination was authorized and met medical necessity to return the injured worker back to full work status, therefore, necessity for such testing rendered, contributed to the therapeutic plan of care and promoted the ability for the employee to return to work as outlined in the ODG treatment guidelines and MDA return to work guidelines adopted by TDI/DWC."

Amount in Dispute: $428.72

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a position summary.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 19, 2017	CPT Code 97750-FC(X8)	$428.72	$339.91

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 §134.203 sets out the reimbursement guidelines for professional services.
3. 28 Texas Administrative Code §134.225, effective July 7, 2016, sets the reimbursement guidelines for the disputed service.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 45-Charge exceeds fee schedule/maximum allowable or contradicted/legislated fee arrangement.

Issues

Does the documentation support billing CPT code 97750-FC? Is the requestor entitled to reimbursement?

Findings

1. The applicable fee guideline for FCEs is found at 28 Texas Administrative Code §134.225.
2. According to the submitted explanation of benefits the respondent denied reimbursement for the FCEs based upon "45-Charge exceeds fee schedule/maximum allowable or contradicted/legislated fee arrangement.
3. 28 Texas Administrative Code §134.225 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."

4. A review of the submitted FCE report supports billed service; therefore, reimbursement is recommended.

5. 28 Texas Administrative Code §134.203(c)(1) states "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83."
   28 Texas Administrative Code §134.203(c)(2) states "The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's 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 following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   On the disputed dates of service, the requestor billed CPT code 97550-FC (X8). CMS published Medical Learning Network (MLN) Matters, effective January 1, 2011 which states in part "Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The Centers for Medicare & Medicaid Services (CMS) is applying a MPPR to the practice expense payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures, furnished to the same patient on the same day, full payment is made for work and malpractice and 80 percent payment for the PE for services furnished in office settings and other non-institutional settings and at 75 percent payment for the PE services furnished in institutional settings." The multiple procedure rule discounting applies to the disputed service.

   The Division conversion factor for 2017 is $57.5.

   The Medicare conversion factor for 2017 is 35.8887.

   Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 77022 which is located in Houston, Texas; therefore, the Medicare locality is "Houston, Texas."

   The Medicare participating amount for CPT code 97750 is $33.81.

Using the above formula, the MAR is $33.81per unit. The requestor billed for 8 units; therefore, $33.81 X 8 + multiple procedure discounting = $339.91. The respondent paid $0.00. The difference between MAR and amount paid is $339.91; this amount is recommended for reimbursement.

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 $339.91.

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 $339.91 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		10/09/2018
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.