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
TAMMIA GUEST, DC

Respondent Name
XL SPECIALTY INSURANCE CO

MFDR Tracking Number
M4-18-4514-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JULY 27, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134. The carrier has not responded or has denied this claim in its entirety following our filing of Request for Reconsideration. Therefore, we are filing for Medical Dispute Resolution at this time per Rule 133.307."

Amount in Dispute: $1,007.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated September 21, 2018: "The carrier's previous denial was that the Functional Capacity Evaluation was denied as not being reimbursable because FCEs are allowed for a maximum of four hours for an initial evaluation or three times for each injured worker. The provider's alleged request for reconsideration does not provide any bill specific substantive explanation for the carrier to modify its previous denial. Accordingly, the provider has now filed a request for reconsideration. However, the provider is required to file a request for reconsideration prior to the filing of a DWC-60 request for medical fee dispute resolution. The absence of such a filing means that the provider has failed to submit an appeal to the carrier pursuant to Division rule 133.307 (f) (3) (A) which permits the Division to dismiss the provider's DWC-60. That should be done in this case."

Response Submitted By: Flahive, Ogden & Latson

Respondent's Position Summary dated September 24, 2018: "We represent GENEX Services, Inc. and its client, XL Specialty Insurance Co…..At this time, Respondent is in the process of reviewing Requestor's request, analyzing the statute to determine whether the services are reimbursable as multiple functional capacity evaluations have been performed on this Claimant."

Response Submitted By: Brown Sims

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 20, 2018	CPT Code 97750-FC-GP(X16)	$1,007.04	$740.78

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 effective May 31, 2012 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 effective March 1, 2008 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. 28 Texas Administrative Code §133.250 effective May 2, 2006 sets out the reconsideration process.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 281-Functional capacity evaluations are allowed a maximum or four hours for an initial or three times for each injured worker.
   - 224-Duplicate charge.

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. The respondent wrote, "The provider's alleged request for reconsideration does not provide any bill specific substantive explanation for the carrier to modify its previous denial. Accordingly, the provider has now filed a request for reconsideration. However, the provider is required to file a request for reconsideration prior to the filing of a DWC-60 request for medical fee dispute resolution."

   Neither party to the dispute submitted the original bill. The bill that was submitted for review was dated February 21, 2018 and is stamped "Amended".

   The preamble of 28 Texas Administrative Code §133.250 Section (d)(1) states, "Comment: Commenters recommend subsection 133.250(d)(1) be amended to require modifiers and number of units in addition to the original billing codes. Agency Response: The Division declines to make the requested change. A reconsideration request may include corrections relating to modifiers and/or number of units. For this reason, a request for reconsideration may include changes in the number of units or modifiers from that in the original bill for proper processing and payment of the bill."

   A review of the April 12, 2018 explanation of benefits (EOB), indicates the requestor billed code 97750 for $1,007.04 and was denied based upon "224-Duplicate charge." This denial supports the code in dispute for the disputed amount was submitted prior to reconsideration; therefore, the respondent's position is not supported.
3. According to the submitted explanation of benefits the respondent denied reimbursement for the FCEs based upon "281-Functional capacity evaluations are allowed a maximum or four hours for an initial or three times for each injured worker."

4. 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."

5. A review of the submitted FCE report supports a Designated Doctor referred claimant to requestor for this test; therefore, per28 Texas Administrative Code §134.225, the limit of tests does not apply in this case.

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

7. 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 2018 is $58.31.

   The Medicare conversion factor for 2018 is 35.9996.

   Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 75247 which is located in Dallas, Texas; therefore, the Medicare locality is "Dallas, Texas."

   The Medicare participating amount for CPT code 97750 is $38.85.

   Using the above formula, the MAR is $62.93 per unit. The requestor billed for 16 units; therefore, $62.93 X 16 + multiple procedure discounting = $740.78. The respondent paid $0.00. The difference between MAR and amount paid is $740.78; 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 $740.78.

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 $740.78 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	10/09/2018 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.