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
Robert Zuniga, D.C.

Respondent Name
Hidalgo County

MFDR Tracking Number
M4-19-2398-01

Carrier's Austin Representative
Box Number 21

MFDR Date Received
December 31, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient did the functional capacity evaluation on 7/5/2018 and that was the third evaluation. According to the Division of workers compensation ruling authorization is not needed for the first three functional capacity evaluations."

Amount in Dispute: $624.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 5, 2018	97750 FC	$624.00	$624.00

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 sets out reimbursement guidelines for specific workers compensation medical bills.
3. 28 Texas Administrative Code §134.203 details reimbursement guidelines for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - B15 – This procedure code requires a functional reporting G code to be billed
   - 10 – The billed service requires the use of a modifier code
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 296 – Service exceeds maximum reimbursement guidelines

Issues

1. Did the insurance carrier respond to the medical fee dispute?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. What rule are applicable to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The Austin carrier representative for Hidalgo Count is Thornton Biechlin Reynolds & Guerra. The carrier's representative acknowledged receipt of the copy of this medical fee dispute on January 9, 2019.

   28 Texas Administrative Code §133.307 states, in relevant part:

   (e) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
   (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days after the date the respondent received the copy of the requestor's dispute** [emphasis added]. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

Review of the documentation finds that no response has been received on behalf of the insurance carrier from the carrier's representative to date. The division concludes that the insurance carrier failed to respond within the timeframe required by §133.307(d)(1). The division will base its decision on the information available.

2. The insurance carrier denied disputed services with claim adjustment reason code 296 – "Service exceeds maximum reimbursement guidelines" and B15 – "This procedure code requires a functional reporting G code to be billed."

   28 TAC §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.

   Review of the submitted documentation found insufficient evidence from the insurance carrier to support the maximum reimbursement guidelines was exceeded. Review of the submitted medical bill found the "FC" modifier was used as required by DWC rules. The reimbursement for the service in dispute will be reviewed per applicable division guidelines discussed below.

3. 28 TAC §134.204 (g) states in pertinent part regarding reimbursement,

   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…

   28 TAC §134.203 (c) 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 (date of service yearly conversion factor)

Review of the submitted medical bill finds 97750 – "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes," with the FC modifier and for 12 units.

The Physician Fee Schedule found at www.cms.gov, for McAllen, Texas finds an allowable of $37.03. The maximum allowable reimbursement (MAR) is calculated as DWC Conversion factor / Medicare conversion factor or 58.31/35.9996 x $37.03 x 12 = $719.75.

28 TAC §134.203 (h) states in pertinent part,

> When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the:
>
> (1) MAR amount;
>
> (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or

Based on the above the least amount is the health care provider's billed amount of $624.00. This amount is recommended.

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 $624.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $624.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		February 15, 2019
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 Rule §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 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. **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.