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
OLD REPUBLIC INSURANCE COMPANY

MFDR Tracking Number
M4-19-4316-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
June 3, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Services billed at the request of designated doctor. Our office has not received an EOB in response to our request for reconsideration submitted."

Amount in Dispute: $247.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No response was received.

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
October 16, 2018	97750-FC-GP	$247.28	$57.41

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 the fee guidelines for the workers' compensation specific services.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 600 – Allowance based on Maximum number of units allowed per fee schedule guidelines and/or service code description
   - 309 – The charge for this procedure exceeds the fee schedule allowance

Issue(s)

1. Did the insurance carrier respond to the medical fee dispute?
2. Where the disputed services referred by a Designated Doctor?
3. Did the requestor submit documentation to support the billing of CPT Code 97750-FC?
4. What rules pertain to the reimbursement of FCE's?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The Austin carrier representative for Old Republic Insurance Company is White Espey PLLC. White Espey PLLC, acknowledged receipt of the copy of this medical fee dispute on June 12, 2019. 28 Texas Administrative Code §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

   As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under 28 Texas Administrative Code §133.307(d)(1).

2. 28 Texas Administrative Code §127.10(c) states, "The designated doctor shall perform additional testing when necessary to resolve the issue in question. The designated doctor shall also refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question and the designated doctor is not qualified to fully resolve the issue in question. Any additional testing or referral required for the evaluation is not subject to preauthorization requirements nor shall those services be denied retrospectively based on medical necessity, extent of injury, or compensability."

   Based upon the submitted documentation, the claimant was referred to the requestor by the Designated Laura Deon, M.D, as part of the Designated Doctor examination process.

3. The requestor billed a total of $741.60 for CPT Code 97750-FC-GP x 12 units, rendered on October 16, 2018. The insurance carrier issued a payment in the amount of $494.32 and the requestor seeks an additional payment amount of $247.28. The insurance carrier reduced the remaining balance of $247.28 with reduction codes, "P12, 600 and 309."

   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. FCEs shall include the following elements."

   Review of the documentation dated, October 16, 2018, documents a total test time of 3 hours. The CMS 1500 documents that the requestor billed for 12 units, 15- minute increments amounts to 3 hours. As a result, the division finds that the insurance carrier's denial reason is not supported. The requestor is therefore entitled to reimbursement pursuant to 28 Texas Administrative Code §134.203 (c).

4. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) 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. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) 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..."

   Procedure code 97750, October 16, 2018, has a Work RVU of 0.45 multiplied by the Work GPCI of 1.007 is 0.45315. The practice expense RVU of 0.6 multiplied by the PE GPCI of 0.986 is 0.5916. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.747 is 0.01494. The sum is 1.05969 multiplied by the DWC conversion factor of $58.31 for a MAR of $61.79. For each extra therapy unit after the first unit of the code with the highest PE, payment is reduced by 50% of the practice expense. This code has the highest PE. The first unit is paid at $61.79. The PE reduced rate is $44.54 at 11 units is $489.94. The total is $551.73. The insurance carrier issued a payment in the amount of $494.32, therefore the requestor is entitled to an additional payment in the amount of $57.41.

The insurance carrier issued a payment in the amount of $494.32 the MAR is $551.73, as a result, the requestor is entitled to an additional payment in the amount of $57.41. Therefore, this amount is recommended.

5. Review of the submitted documentation finds that the requestor is entitled to an additional payment in the amount of $57.41. Therefore, 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 $57.41.

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 $57.41 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		August 23, 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 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.