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
Austin Chiropractic Associates, PA

Respondent Name
General Motors, LLC

MFDR Tracking Number
M4-19-4825-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
July 9, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The code 97750 was performed following a Designated Doctor referral and therefore billed in conjunction with '99456-**W5**'…"

Amount in Dispute: $209.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The designated doctor billed for the whole examination and then billed for testing used to determine maximum medical improvement and/or the impairment rating. However, per DWC Rule … 134.250(1), the testing is included in the reimbursement for the exam; it is not billed separately."

Response Submitted by: Downs-Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 14, 2019	Functional Capacity Examination (97750)	$209.96	$0.00

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 §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

- 906 – IN accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor), component code of comprehensive medicine, evaluation and management services procedure (90000-99999) has been disallowed.
- W3 – Additional payment made on appeal/reconsideration.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to additional reimbursement?

Findings

Austin Chiropractic Association, PA is seeking separate reimbursement for a functional capacity examination performed on May 14, 2019 on the same day and by the same provider that performed a division-ordered designated doctor examination to determine maximum medical improvement (MMI) and impairment rating (IR).

Indemnity Insurance Company of North America denied payment for this service, arguing that the FCE was not separately payable.

Tests to determine IR of musculoskeletal body areas are included in the MMI and IR. See 28 TAC §134.250.

For this reason, no additional reimbursement is recommended.

Conclusion

For the reasons stated above, the DWC finds that reimbursement is due for the service in dispute. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	October 3, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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.