



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

Austin Chiropractic Associates, PA

Respondent Name

Indemnity Insurance Company of North America

MFDR Tracking Number

M4-19-4826-01

Carrier's Austin Representative

Box Number 15

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-WS'..."

Amount in Dispute: \$157.47

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 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 16, 2019	Functional Capacity Examination (97750)	\$157.47	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
- 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.
- 947 – Upheld. No additional allowance has been recommended.

Issues

Is the requestor entitled to additional reimbursement?

Findings

Austin Chiropractic Association, PA is seeking reimbursement for a functional capacity examination performed on May 16, 2019, in conjunction with an examination to determine maximum medical improvement (MMI) and impairment rating (IR).

Indemnity Insurance Company of North America denied payment for this service, arguing that this service is included in the MMI and IR examination.

Reimbursement for additional testing associated with an examination to determine MMI and IR is provided only when the doctor performs testing for an **impairment rating** of non-musculoskeletal body areas.¹

Billing documentation presented to the DWC indicates that Dr. Forster found the injured employee not to be at maximum medical improvement. No impairment rating was performed. When a designated doctor determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed.²

For the reasons above, no reimbursement can be recommended for the service in question.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement is due. 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 25, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

¹ 28 TAC §134.250(4)(D)
² 28 TAC §134.250(2)(A)

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.