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
Mitsui Sumitomo Insurance Company of America

MFDR Tracking Number
M4-20-0305-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 1, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I ordered / performed a functional assessment billed by utilizing AMA CPT code '97750', which is a completely distinct and separate procedure from the procedure 99456 W5 WP."

Amount in Dispute: $209.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider was not appointed on any issues other than MMI and impairment rating. It is the carrier's position that he was not required and should not have provided a FCE. It was not an exam that was necessary for purposes of MMI and impairment rating."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 23, 2019	Functional Testing - 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 (DWC).

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:
   - Notes: "Per rule 134.250(1) exam includes all time spent on the exam; consultation w/IW, review of records, narrative preparation, calculation tables, testing, figures and worksheets."
   - R84 – CCI: Most Extensive Procedures

- 236 – This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.

Issues

Is the requestor entitled to reimbursement for the service in question?

Findings

Austin Chiropractic Associates, PA is seeking reimbursement for an examination consisting of range of motion testing and strength testing. Dr. Forster argued that "the code 97750 was performed following a Designated Doctor referral and therefore billed in conjunction with '99456-**W5**' … **Any additional testing is performed separately to the exams, and not as a component of the exams**."

The insurance carrier denied payment for the examination stating that it was included in the examination to determine maximum medical improvement (MMI) and impairment rating (IR).

Range of motion, sensory, and strength testing are included in an examination to determine the impairment of a musculoskeletal body area.[1] Explanations of benefits submitted with the dispute indicate that Austin Chiropractic Associates, PA was reimbursed in full for the examination to determine MMI and IR. No additional reimbursement is recommended.

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

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.

[1] 28 TAC §§134.250(1)(E) and (4)(C)(iii) – (v)