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
SIMON J. FORSTER, DC

Respondent Name
UNITED STATES FIRE INSURANCE CO

MFDR Tracking Number
M4-20-2066-01

Carrier's Austin Representative
Box Number 53

MFDR Date Received
APRIL 24, 2020

REQUESTOR'S POSITION SUMMARY

"It is out position that you, the carrier, are in error for denying reimbursement for code 97750-FC performed in conjunction with a designated doctor's evaluation on this date of service…Any additional testing is performed separately to the exams, and not as a component of the exams."

Amount in Dispute: $209.96

RESPONDENT'S POSITION SUMMARY

The respondent did not respond to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 20, 2020	CPT Code 97750 (X4) Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes	$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 (TAC) §133.307, effective May 31, 2012 sets out the procedures for resolving a medical fee dispute.
2. 28 TAC §134.250, effective July 7, 2016, sets the policy for billing and reimbursement guidelines for Maximum Medical Improvement (MMI) and/or Impairment Rating (IR) examinations.

3. The insurance carrier reduced payment for the disputed services based upon the following claim adjustment reason 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.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - W3-Additional payment made on appeal/reconsideration.
   - 1003-In response to your appeal of our previous re-evaluation, no significant additional documentation or information regarding this claim has been received. Our position remains unchanged on the same questions that were previously posed by the provider. Therefore, no additional allowance is recommended.

Issues

Is the requestor entitled to reimbursement for CPT code 97750 (X4) rendered on February 20, 2020?

Findings

1. The Austin carrier representative for United States Fire Insurance Co is Hoffman Kelley LLP. Hoffman Kelley LLP received a copy of this medical fee dispute on April 28, 2020. Rule §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 §133.307(d)(1).

2. The requestor is seeking medical fee dispute resolution in the amount of $209.96 for CPT code 97750 (X4) rendered on February 20, 2020.

3. The respondent denied reimbursement for CPT code 97750 based upon unbundling. (“97” and “906” listed above).

4. On the disputed date of service, the requestor billed CPT codes 99456-NM and 97750.

5. The following statutes are applicable to the disputed service:
   - 28 Texas Administrative Code §134.250(2)(A) states,
     If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this section. Modifier "NM" shall be added.
   - 28 TAC §134.250 (1) states, “The total maximum allowable reimbursement (MAR) for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include:
     (A) the examination;
     (B) consultation with the injured employee;
     (C) review of the records and films;
     (D) the preparation and submission of reports (including the narrative report, and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets; and
     (E) tests used to assign the IR, as outlined in the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), as stated in the Labor Code and Chapter 130 of this title.”

   The requestor did not support that the disputed physical performance or measurement test was not part of the Designated Doctor evaluation used to determine the claimant was not at MMI, and that

it is eligible for separate reimbursement. The DWC finds the requestor is not entitled to reimbursement.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the DWC has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		08/21/2020
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 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 with the DWC. **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.