TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
MILLENNIUM CHIROPRACTIC

Respondent Name
AMERICAN ZURICH INSURANCE COMPANY

MFDR Tracking Number
M4-22-1684-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
April 5, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 24, 2021 through August 9, 2021	99215 and 97750-FC x 3	$2,667.84	$1,973.72
	Total	$2,667.84	$1,973.72

Requestor's Position

"THE CARRIER HAS NOT SENT US EOBs FOR THIS CLAIM SINCE DECEMBER 2020 WITH ONLY TWO EXCEPTIONS. WE HAVE BILLED DOZENS AND DOZENS OF DATES SINCE THAT TIME. ADDITIONALLY, DR. VANDERWERFF HAS CONFIRMED IN RECORDED PHONE CALLS WITH BILL REVIEW THAT THEY HAVE THESE DATES IN THEIR SYSTEM, AND HAVE APPROVED THEM FOR PAYMENT, YET, THE CARRIER HAS NEVER SENT PAYMENT OR EOBs."

Amount in Dispute: $2,667.84

Respondent's Position

"The following applies to functional capacity evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. Three FCE's have already been reimbursed on 11/20/20, 2/1/21, 4/28/21."

Response Submitted by: Gallagher Bassett

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.230 sets out the fee guideline for return-to-work rehabilitation programs.
3. 28 TAC §134.600 sets out preauthorization, concurrent utilization review, and voluntary certification of health care.
4. 28 TAC §134.225, effective July 7, 2016, sets the reimbursement guidelines for FCEs.

Denial Reasons

Neither party submitted copies of EOBs for the FCE's in dispute.

Issues

1. Did the requestor submit a bill with a valid state license number?
2. Did the requestor waive the right to medical fee dispute resolution for date of service March 24, 2021?
3. Did the requestor meet the requirements of 28 TAC 133.307(c)(2)(K)?
4. What rules apply to the reimbursement of CPT Code 97750-FC?
5. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for professional medical services rendered on March 24, 2021 through August 9, 2021.

   28 Texas Administrative Code (TAC) §42.20 states, "(a-b) Licensed Doctor of Medicine, osteopathy, chiropractic, and podiatry may act as treating doctors for injured workers entitled to benefits under the Act. (b) Treating doctors may prescribe treatment to be rendered by other persons licensed to provide health care, or by persons not licensed to provide health care who work under the direct supervision and control of the treating."

   The DWC issued a cease-and-desist order dated December 21, 2020, which states in part, "It is ordered that Eric A. Vanderwerff, D.C., must immediately cease and desist from the following: Providing health care services in the Texas workers' compensation system, including serving as a treating doctor, until he notifies DWC that the Texas Board of Chiropractic Examiners has allowed him to practice chiropractic medicine."

   In addition, the cease-and-desist order states "On October 1, 2020, Dr. Vanderwerff's license expired and remains expired as of December 18, 2020."

The DWC finds that the disputed services were rendered by the following:

Dates of service March 24, 2021 and April 28, 2021 were rendered and billed by Karen Austin, D.C.

Dates of service June 2, 2021 and August 9, 2021 were rendered and billed by Christopher Blair, D.C.

2. The requestor seeks reimbursement for medical services rendered on March 24, 2021. 28 TAC §133.307(c) (1) states in pertinent part, "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute."

   The date of service in dispute is March 24, 2021. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on April 5, 2022. This date is later than one year after the date of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in 28 TAC §133.307(c) (1) (B). The Division concludes that the requestor has failed to timely file this date of service with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for date of service March 24, 2021.

3. The requestor seeks reimbursement for CPT Code 97750-FC x 3, rendered on April 28, 2021, June 2, 2021, and August 9, 2021. Neither party submitted copies of EOBs with the DWC060 request/response.

   28 TAC §133.307(c)(2)(K)states, "(2) Health Care Provider or Pharmacy Processing Agent Request. The requestor must send the request to the division in the form and manner prescribed by the division by any mail service, personal delivery, or electronic transmission as described in §102.5 of this title. The request must include… (K) each explanation of benefits or e-remittance (collectively "EOB") related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB…"

   Review of the DWC060 included sufficient documentation to support that the requestor made an attempt to obtain EOBs for the services in dispute. As, a result, the requestor is entitled to reimbursement pursuant to 28 TAC §134.225.

4. The applicable fee guideline for FCEs is found at 28 TAC §134.225.

   28 TAC §134.225 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."

28 TAC §134.203(b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

On the disputed dates of service, the requestor billed CPT code 97550-FC. The multiple procedure rule discounting applies to the disputed service.

Medicare Claims Processing Manual Chapter 5, 10.7-effective June 6, 2016, titled Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services, states:

> Full payment is made for the unit or procedure with the highest PE payment.
>
> For subsequent units and procedures with dates of service prior to April 1, 2013, furnished to the same patient on the same day, full payment is made for work and malpractice and 80 percent payment is made for the PE for services submitted on professional claims (any claim submitted using the ASC X12 837 professional claim format or the CMS-1500 paper claim form) and 75 percent payment is made for the PE for services submitted on institutional claims (ASC X12 837 institutional claim format or Form CMS-1450).
>
> For subsequent units and procedures with dates of service on or after April 1, 2013, furnished to the same patient on the same day, full payment is made for work and malpractice and 50 percent payment is made for the PE for services submitted on either professional or institutional claims.
>
> To determine which services will receive the MPPR, contractors shall rank services according to the applicable PE relative value units (RVU) and price the service with the highest PE RVU at 100% and apply the appropriate MPPR to the remaining services. When the highest PE RVU applies to more than one of the identified services, contractors shall additionally sort and rank these services according to highest total fee schedule amount, and price the service with the highest total fee schedule amount at 100% and apply the appropriate MPPR to the remaining services.

The MPPR Rate File that contains the payments for 2021 services is found at https://www.cms.gov/Medicare/Billing/TherapyServices/index.html

28 TAC §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…"

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

- The dates of service were rendered in 2021.
- MPPR rates are published by carrier and locality.
- Review of the CMS-1500 finds that the services were rendered in zip code 75061; the Medicare locality is "Dallas, Texas."
- The Medicare participating amount for CPT code 97750 at this locality is $35.06 for the first unit, and $25.75 for subsequent units.
- The DWC conversion factor for 2021 is 61.17.
- The Medicare conversion factor for 2021 is 34.8931.

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

Using the above formula, the MAR for CPT Code 97750 is $61.46 for the first unit, and $45.14 for the subsequent units.

Date of service: April 28, 2021, 97750-FC x 16 units

- $61.46 for the first unit
- $45.14 for subsequent units - 15 units x $45.14 = $677.12
- $61.46 + $677.12 = total MAR of $738.58.
- The respondent paid $0.00.
- The difference between MAR and amount paid is $738.58; this amount is recommended.

Date of service: June 2, 2021, 97750-FC x 16 units

- $61.46 for the first unit
- $45.14 for subsequent units - 15 units x $45.14 = $677.12
- $61.46 + $677.12 = total MAR of $738.58.
- The respondent paid $0.00.
- The difference between MAR and amount paid is $738.58; this amount is recommended.

Date of service: June 2, 2021, 97750-FC x 12 units

- $61.46 for the first unit
- $45.14 for subsequent units - 11 units x $45.14 = $496.56
- $61.46 + $496.56 = total MAR of $566.91.
- The respondent paid $0.00.
- The difference between MAR and amount paid is $558.02; this amount is recommended.

5. The DWC finds that the requestor is therefore entitled to a total reimbursement amount of $1,973.72.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The DWC finds the requester has established that reimbursement of $1,973.72 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor $1,973.72 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	_____	July 22, 2022
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.