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
INTEGRATED HEALTH SERVICES

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-16-3882-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
AUGUST 30, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We billed the attached $1200 in March 2016 with 16 units of CPT code 97750, but the MAR was not paid…This FCE was a DESIGNATED DOCTOR EXAM"

Amount in Dispute: $1,200.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It has been determined that ESIS Med Bill Impact will stand on the original recommendation of $900.00. According to National Correct Coding Initiative, 97750 is not payable when billed with 99456."

Response Submitted By: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 4, 2016	CPT Code 97750-FC (X16 units) Functional Capacity Evaluation	$1,200.00	$834.40

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 §134.204 and §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

- 082-Per National Correct Coding Initiative Edits, this code is not separately reimbursable.
- 330-CCI Comprehensive/Component procedure.
- 236-This procedure or procedure/modifier combination is not compensable with another procedure or procedure/modifier.
- CIQ378-This appeal is denied as we find the original review reflected the appropriate allowance for the service rendered. We find that no additional recommendation is warranted at this time.

- 193-Original payment decision is being maintained. This claim was processed properly the first time.
- 148-This procedure on this date was previously reviewed.
- 18-Duplicate claim/service.

Issues

Is the requestor entitled to reimbursement for the functional capacity evaluation rendered on Mach 4, 2016?

Findings

1. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204.
2. On the disputed date of service, the requestor billed CPT code 97750-FC, 99456-NM, 99456-RE-W8, 99456-MI and 99080-73.
3. The American Medical Association (AMA) Current Procedural Terminology (CPT) defines CPT code 97750 as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes."
4. The requestor appended modifier "FC" to code 97750. 28 Texas Administrative Code §134.204(n)(3) states,

   > The following Division Modifiers shall be used by HCPs billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes. (3) FC, Functional Capacity-This modifier shall be added to CPT Code 97750 when a functional capacity evaluation is performed.

5. The respondent wrote that reimbursement was not recommended because "According to National Correct Coding Initiative, 97750 is not payable when billed with 99456."
6. 28 Texas Administrative Code §134.204(j)(3)(C) states "An examining doctor, other than the treating doctor, shall bill using CPT Code 99456."
7. 28 Texas Administrative Code §134.204(j)(5) states,

   > If the examination for the determination of MMI and/or the assignment of IR requires testing that is not outlined in the AMA Guides, the appropriate CPT code(s) shall be billed and reimbursed in addition to the fees outlined in paragraphs (3) and (4) of this subsection.

   Because the requestor billed for Division specific services found in 28 Texas Administrative Code §134.204, specifically the Designated Doctor examination, code 99456, and a functional capacity evaluation, 97750-FC, the respondent's denial based upon Medicare CCI edits is not supported.
8. 28 Texas Administrative Code §134.204(g) 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.

9. Per 28 Texas Administrative Code §134.203(c)(1)(2), the following formula is used to calculate the Maximum Allowable Reimbursement (MAR): (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = MAR.
10. The 2016 DWC conversion factor for this service is 58.62.
11. The Medicare Conversion Factor is 35.8043.
12. Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 78336 which is located in Aransas Pass, Texas; therefore, the Medicare locality is "Rest of Texas."
13. The Medicare participating amount for CPT code 97750 is $31.85.
14. Using the above formula, the MAR is $52.15 per unit. The requestor billed for 16 units; therefore, $52.15 X 16 = $834.40. The respondent paid $0.00. The requestor is due the difference between MAR and amount paid of $834.40.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $834.40.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $834.40 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		09/29/2016
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 Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division 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 Division. **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.

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