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
Troy Robinson, D.C.

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-17-1593-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 27, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DESIGNATED DR REFERRED TESTING NO PAYMENT RECEIVED"

Amount in Dispute: $845.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We had no record of these bills in our payment system but, as the provider has submitted documentation to indicate timely billing we have now entered both bills and issued payment."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 8, 2016	Functional Capacity Evaluation (97750-FC)	$845.28	$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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.235 sets out the fee guidelines for functional capacity evaluations provided on or after September 1, 2016.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - Z710 – The charge for this procedure exceeds the fee schedule allowance.
   - P300 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - PNFC – The reimbursement is based on the CMS Physician Fee Schedule non-facility site of service rate.

Issues

Is Troy Robinson, D.C. entitled to additional reimbursement?

Findings

Dr. Robinson is seeking reimbursement of $845.28 for a functional capacity evaluation, 16 units, provided on September 8, 2016.

28 Texas Administrative Code §134.225 adopts the 28 Texas Administrative Code §134.203(c) maximum allowable reimbursement (MAR) calculation by reference. The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR adopted by 28 Texas Administrative Code §134.203(c) is calculated by substituting the division conversion factor. The division conversion factor (DWC CF) for 2016 is $56.82.

The MAR for procedure code 97750-FC on date of service September 8, 2016, is calculated as follows:

The relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.000 is 0.450. The practice expense (PE) RVU of 0.46 multiplied by the PE GPCI of 0.920 is 0.4232. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.822 is 0.01644. The sum of 0.88964 is multiplied by the division conversion factor of $56.82 for a total of $50.55. This total is multiplied by 16 units for a MAR of $808.80.

The total MAR for the service in question is $808.80. Per Explanation of Benefits dated February 10, 2017, New Hampshire Insurance Company reimbursed $808.80. No further reimbursement is recommended.

Conclusion

For the reasons stated above, the Division 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 division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	August 9, 2017
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 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. **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.