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
GULF COAST FUNCTIONAL TESTING

Respondent Name
CITY OF HOUSTON

MFDR Tracking Number
M4-18-4527-01

Carrier's Austin Representative
Box Number 29

MFDR Date Received
JULY 27, 2018

REQUESTOR'S POSITION SUMMARY

"The above dates of service were denied by the carrier because 'of the modifier code'. Our records indicate that the carrier has processed and PAID for other dates of service with the same procedure and modifier code."

Amount in Dispute: $506.24

RESPONDENT'S POSITION SUMMARY

"Requestor is not entitled to payment because it did not properly bill for the disputed service. It billed using HCPCS code 97750, which is an 'Always Therapy' code under Medicare payment policies. As a result, it required one of the three therapy modifiers (GN, GO, or GP). This is clear from Medicare Claims Processing Change Requests (CRs) and other coding directives published by the Centers for Medicare & Medicaid Services (CMS) which are attached…Requestor did not include the required modifier and Respondent denied payment on that basis."

Response Submitted By: Stone Loughlin & Swanson, LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 8, 2018	CPT Code 97750-FC (X8) Functional Capacity Evaluation (FCE)	$506.24	$382.21

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 (TAC), effective May 31, 2012 sets out the procedures for resolving a medical fee dispute.

2. 28 TAC §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.
3. 28 TAC §134.210, effective July 7, 2016, sets out the medical fee guideline for workers' compensation specific services in the Texas workers' compensation system.
4. 28 TAC §134.225, effective July 7, 2016, sets the reimbursement guidelines for FCEs.
5. 28 TAC §134.235, effective July 7, 2016, sets the reimbursement guideline for return to work/evaluation of medical care.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment code:
   - 4-The procedure code is inconsistent with the modifier used or a required modifier is missing.
   - 10-The billed service required the use of a modifier code.
   - W3-
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

Is the requestor entitled to reimbursement for CPT code 97750-FC (X8) rendered on May 8, 2018?

Findings

1. The requestor is seeking medical fee dispute resolution for CPT code 97750-FC (X8) rendered on May 8, 2018 in the amount of $506.24.
2. CPT code 97750- is described as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes" The requestor appended modifier "FC" to code 97750.
3. According to the explanation of benefits, the carrier denied reimbursement for the disputed FCE based upon "4-The procedure code is inconsistent with the modifier used or a required modifier is missing," and "10-The billed service required the use of a modifier code."
4. The respondent wrote, "Requestor is not entitled to payment because it did not properly bill for the disputed service. It billed using HCPCS code 97750, which is an 'Always Therapy' code under Medicare payment policies. As a result, it required one of the three therapy modifiers (GN, GO, or GP). This is clear from Medicare Claims Processing Change Requests (CRs) and other coding directives published by the Centers for Medicare & Medicaid Services (CMS) which are attached…Requestor did not include the required modifier and Respondent denied payment on that basis."
5. The following statute is applicable to the disputed services:
   - 28 TAC §134.210(a) states,

     Specific provisions contained in the Labor Code or division rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the Centers for Medicare and Medicaid Services (CMS) in administering the Medicare program. Independent review organization decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title, which are made on a case-by-case basis, take precedence, in that case only, over any division rules and Medicare payment policies.

   - 28 TAC §134.210(b) states,

     Payment policies relating to coding, billing, and reporting for workers' compensation specific codes, services, and programs are as follows:

(2) Modifying circumstance shall be identified by use of the appropriate modifier following the appropriate Level I (CPT codes) and Level II HCPCS codes. Where HCPCS modifiers apply, insurance carriers shall treat them in accordance with Medicare and Texas Medicaid rules. Additionally, division-specific modifiers are identified in subsection (e) of this section. When two or more modifiers are applicable to a single HCPCS code, indicate each modifier on the bill.

- 28 TAC §134.210(e) states,

  The following division modifiers shall be used by health care providers 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

- 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(c)(1) states,

  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.

7. The DWC finds the following:

- The requestor billed for the disputed FCE with CPT code 97750 and "FC" modifier.
- The respondent denied reimbursement for CPT code 97750-FC based upon "a required modifier is missing".
- The respondent contends per CMS, the "GP" modifier is required when billing code 97750.
- The "GP" modifier is required by CMS for physical therapy services identified as "always therapy".
- "Always Therapy" codes are defined as, "These codes always require a therapy modifier – GP, GO, or GN- to indicate that they're furnished under a physical therapy, occupational therapy, or speech-language pathology plan of care, respectively."
- No documentation was found to support that the services were furnished under a physical therapy, occupational therapy, or speech-language pathology plan of care.
- A GP, GO, or GN modifier was not required.
- The FCE is a DWC specific service.
- The requestor billed for the FCE in accordance with 28 TAC §134.225.
- Per TAC §134.225 FCEs shall be reimbursed in accordance with §134.203(c)(1).

- The requestor is due reimbursement for the FCE.

8. 28 TAC §134.203(c)(1) states "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."

   28 Texas Administrative Code §134.203(c)(2) states "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. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."
   Medicare Claims Processing Manual Chapter 5, 10.3.7-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.

   On the disputed dates of service, the requestor billed CPT code 97550-FC (X8). The multiple procedure rule discounting applies to the disputed service.

   The DWC conversion factor for 2018 is $58.31.

   The Medicare conversion factor for 2018 is 35.9996.

   Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 77076 which is located in Houston, Texas.

   The Medicare participating amount for CPT code 97750 in Houston, TX is $39.06 and MMPR is $28.13.

   Using the above formula, the MAR is $63.27 for the first unit, and $45.56 for each additional unit. The MAR is $382.21. The respondent paid $0.00. The requestor is due the difference between MAR and amount paid of $382.21.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $382.21.

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 DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of $382.21 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

______________________	______________________	12/12/2019
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 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.