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
NORTH TEXAS PAIN RECOVERY CENTER

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-19-3745-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
APRIL 8, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Hartford did improperly reduce the amount of reimbursement due for a functional capacity evaluation stating that precertification is required. 28 TAC Part 2 §134.225 (enclosed) states that three FCE's are reimbursable for each compensable injury."

Amount in Dispute: $494.32

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill has been disputed as the service was not preauthorized. We are attaching the EOB that supports the denial."

Response Submitted By: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 6, 2019	CPT Code 97750-FC (X8) Functional Capacity Evaluation (FCE)	$494.32	$358.21

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.

Background

1. 28 Texas Administrative Code §133.307, effective May 31, 2012 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600, effective March 30, 2014, requires preauthorization for specific treatments and services.

3. 28 Texas Administrative Code §137.100, effective January 18, 2007, sets out the use of the treatment guidelines.
4. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.
5. 28 Texas Administrative Code §134.225, effective July 7, 2016, sets the reimbursement guidelines for FCEs.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - D49-Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
   - W3-In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - D00-Based on further review, no additional allowance is warranted.

Issues

Is the requestor entitled to reimbursement for CPT code 97750-FC rendered on March 6, 2019?

Findings

1. The requestor is seeking medical fee dispute resolution for CPT code 97750-FC-GP rendered on March 6, 2019 in the amount of $494.32.
2. According to the explanation of benefits, the carrier denied reimbursement for the disputed FCE based upon a lack of preauthorization.
3. 28 Texas Administrative Code §134.600(p)(12) requires preauthorization for:

   > treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits).

   According to the Fitness for Duty Chapter of the Official Disability Guidelines (ODG), an FCE is a recommended treatment.
4. The applicable fee guideline for FCEs is found at 28 Texas Administrative Code §134.225.
5. 28 Texas Administrative Code §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. "
6. The division reviewed the submitted documentation and finds neither party to the dispute submitted any documentation to support that the requestor exceeded the three tests allowed by the fee guideline; therefore, the disputed FCE did not require preauthorization and reimbursement is recommended.
7. 28 Texas Administrative Code §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."

On the disputed dates of service, the requestor billed CPT code 97550-FC (X12). CMS published Medical Learning Network (MLN) Matters, effective January 1, 2011 which states in part "Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The Centers for Medicare & Medicaid Services (CMS) is applying a MPPR to the practice expense payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures, furnished to the same patient on the same day, full payment is made for work and malpractice and 80 percent payment for the PE for services furnished in office settings and other non-institutional settings and at 75 percent payment for the PE services furnished in institutional settings." The multiple procedure rule discounting applies to the disputed service.

The Division 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 76016 which is located in Arlington, Texas; therefore, the Medicare locality is "Fort Worth, Texas."

The Medicare participating amount for CPT code 97750 is $35.35.

Using the above formula, the MAR is $58.05 per unit. The requestor billed for 8 units; therefore, $58.05 X 8 + multiple procedure discounting = $358.21. The respondent paid $0.00. The difference between MAR and amount paid is $358.21; this amount is recommended for reimbursement.

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 $358.21.

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 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 $358.21 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

______________________	______________________	5/2/2019
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 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.