



**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**

TROY ROBINSON, DC

**Respondent Name**

AMERICAN AUTOMOBILE INSURANCE

**MFDR Tracking Number**

M4-20-2146-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

MAY 4, 2020

**REQUESTOR'S POSITION SUMMARY**

"DESIGNATED DOCTOR REFERRED TESTING INCORRECT REDUCTION."

**Amount in Dispute:** \$450.32

**RESPONDENT'S POSITION SUMMARY**

The respondent did not submit a response to this request for medical fee dispute resolution.

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 10, 2019	CPT Code 97750-FC-GP ( X16) Functional Capacity Evaluation (FCE)	\$450.32	\$235.03

**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**

- 28 Texas Administrative Code §133.307 (TAC), effective May 31, 2012 sets out the procedures for resolving a medical fee dispute.
- 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.
- 28 TAC §134.225, effective July 7, 2016, sets the reimbursement guidelines for FCEs.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment code:
  - P12-Workers compensation jurisdictional fee schedule adjustment.

- 600-Allowance based on maximum number of units allowed per fee schedule guidelines and/or service code description.

### Issues

Is the requestor entitled to additional reimbursement for CPT code 97750-FC-GP (X16) rendered on December 10, 2019?

### Findings

1. The Austin carrier representative for American Automobile Insurance Co is Flahive Ogden & Latson. Flahive Ogden & Latson received a copy of this medical fee dispute on May 12, 2020. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information

As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

2. The requestor is seeking medical fee dispute resolution for CPT code 97750-FC-GP (X16) rendered on December 10, 2019 in the amount of \$450.32.
3. According to the explanation of benefits, the carrier paid for the disputed FCE based upon the fee guideline.
4. The applicable fee guideline for FCEs is found at 28 TAC §134.225.
5. 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. "

6. The requestor indicated that the disputed FCE was performed based upon a Designated Doctor referral; therefore, per 28 TAC §134.225 the requestor did not exceed the maximum of four hours.
7. 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."

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

On the disputed dates of service, the requestor billed CPT code 97550-FC (X16). The multiple procedure rule discounting applies to the disputed service.

*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.

The *MPPR Rate File* that contains the payments for 2019 services is found at

<https://www.cms.gov/Medicare/Billing/TherapyServices/index.html>.

- MPPR rates are published by carrier and locality.
- Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 78228 which is located in San Antonio, Texas; therefore, the Medicare locality is “Rest of Texas.”
- The carrier code for Texas is 4412 and the locality code for “Rest of Texas” is 99.
- The Medicare participating amount for CPT code 97750 at this locality is \$34.37 for the first unit, and \$25.58 for subsequent units.

The DWC conversion factor for 2019 is 59.19

The Medicare conversion factor for 2019 is 36.0391.

Using the above formula, the MAR is \$56.45 for the first unit, and \$42.01 for the subsequent units, for a total of \$686.63. The respondent paid \$451.60. The DWC finds the requestor is due additional reimbursement of \$235.03.

## **Conclusion**

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$235.03.

**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 \$235.03 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

6/26/2020  
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.**