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
AUSTIN CHIROPRACTIC ASSOCIATES, PA

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number
M4-20-2403-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 4, 2020

Response Submitted By:
ESIS

REQUESTOR'S POSITION SUMMARY

"I ordered/performed a functional assessment, which is a completely distinct and separate procedure, billed utilizing AMA CPT code '97750.' Therefore, the use of a '-FC' modifier is inappropriate and NOT required for the reimbursement of this service. The code 97750 is code for functional testing…This assessment is more appropriate to utilize when specific functional tests are required to answer a question pertaining to specific functional ability, (without requiring a complete assessment comprised of all the 14 sub-component element requirements outlined in TAC §134.204(g) for a full functional capacity evaluation."

RESPONDENT'S POSITION SUMMARY

"According to NCCI edits 97750 cannot be billed with 99456. Also, MMI/IR reimbursement includes tests used to assign an IR."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 4, 2020	97750 x 4 units Physical Performance Test	$209.96	$193.23

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 §134.250, provides the policies and procedures for MMI/IR.
3. 28 Texas Administrative Code §134.203, sets the fee guideline for professional services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - The appropriate modifier was not utilized
   - National Correct Coding Initiative edit – either mutually exclusive of or integral to another service performed on the same day
   - 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

Issues

1. What is the applicable fee guideline?
2. Is the respondent's denial of payment supported?
3. Is the requestor due reimbursement?

Findings

1. The applicable fee guideline for physical performance test is 28 Texas Administrative Code (TAC) §134.203.
2. According to the submitted explanation of benefits the respondent denied reimbursement for the FCEs based upon "The appropriate modifier was not utilized."

   The respondent wrote "According to NCCI edits 97750 cannot be billed with 99456. Also, MMI/IR reimbursement includes tests used to assign an IR."

   28 TAC §134.250(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 section."

   On the disputed date of service, the requestor billed for CPT code 97750 in conjunction with 99456-W5-WP. The requestor wrote "The code 97750 is code for functional testing…This assessment is more appropriate to utilize when specific functional tests are required to answer a question pertaining to specific functional ability, (without requiring a complete assessment comprised of all the 14 sub-component element requirements outlined in TAC §134.204(g) for a full functional capacity evaluation."

   CPT code 97750 is defined as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes." CPT code 97750 requires direct one-on-one patient contact.

   The division finds the respondent did not support that physical performance tests, CPT code 97750, was a test required by the AMA guides for MMI/IR; therefore, the denial is not supported, and the requestor is due reimbursement.
3. 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 TAC §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."

CPT Code 97750 is considered an "Always Therapy" code. Per 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 X 4 units. The multiple procedure rule discounting applies to the disputed service.

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

The DWC conversion factor for 2020 is 60.32.
The Medicare conversion factor for 2020 is 36.0896.
Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 78758 which is in Austin, Texas.

The Medicare participating amount for CPT code 97750 in Austin, TX is $36.22 and MMPR is $26.46.

Using the above formula, the MAR is $60.54 for the first unit, and $44.23 for each additional unit.

The requestor billed a total of 4 units.

The MAR for the first unit is $60.54 x 1 unit = $60.54.

The MAR for the additional 3 units is $44.23 x 3 units = $132.69 for a total MAR of $193.23. The respondent paid $0.00. The requestor is due the difference between MAR and amount paid of $193.23.

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 $193.23.

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 $193.23 plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	Date
		June 26, 2020

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 TAC §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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804- 4812.