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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MILLENIUM CHIROPRACTIC

Respondent Name
AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number
M4-20-2830-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JULY 30, 2020

REQUESTOR'S POSITION SUMMARY

"FCEs do NOT require pre-authorization, and MUST BE PAID."
Disputed Amount: $1,529.08

RESPONDENT'S POSITION SUMMARY

"The provider filed the DWC-60 with the Division on June 30, 2020. This is more than one year after both dates of service."

Supplemental Response: "There are two EOBs that were reprocessed on September 9, 2020. Each of those EOBs recommended reimbursement of $764.54. We have also attached a copy of the payment information for each of those EOBs. We have also attached an EOB dated November 5, 2020 in payment of interest."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 14, 2019	CPT Code 97750-FC (X14)	$764.54	$0.00
July 29, 2019	CPT Code 97750-FC (X14)	$764.54	$0.00
TOTAL		$1,529.08	$0.00

AUTHORITY

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 §134.600, effective November 1, 2018, requires preauthorization for specific treatments and services.
3. 28 TAC §137.100, effective January 18, 2007, sets out the use of the treatment guidelines.
4. 28 TAC §134.225, effective July 7, 2016, sets the reimbursement guidelines for FCEs.
5. 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.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment code:
   - 197-Precertification/authorization/notification absent.
   - 18-Exact duplicate claim/service.

Issue

Is the requestor entitled to additional reimbursement for FCE rendered on May 14 and July 29, 2019?

Findings

1. The requestor is seeking medical dispute resolution for CPT code 97750-FC rendered on May 14, and July 29, 2019.
2. According to the explanation of benefits, the carrier initially denied payment for the disputed FCEs based upon a lack of preauthorization. The respondent did not maintain the denial and issued payment of $1,529.08 for the FCEs based upon the fee guideline.
3. The applicable fee guideline for FCEs is found at 28 TAC §134.225.

   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. "

   The requestor performed FCEs on May 14 and July 29, 2019. The requestor did not support that these FCEs were ordered by the division; therefore, the time limits listed above apply. The respondent did not submit any documentation to support the claimant had other FCEs performed prior to these dates; therefore, the May 14, 2019 will be calculated as the initial test and the July 29, 2019 is an interim test. Per 28 TAC §134.225 the maximum for an initial test is four hours and the interim test is two hours.

   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.

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 75061 which is located in Irving, Texas; therefore, the Medicare locality is "Dallas, Texas."
- The carrier code for Texas is 4412 and the locality code for Dallas is 11.
- The Medicare participating amount for CPT code 97750 at this locality is $35.97 for the first unit, and $26.47 for subsequent units.

The DWC conversion factor for 2019 is 59.19.

The Medicare conversion factor for 2019 is 36.0391.

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

Using the above formula, the MAR is $59.08 for the first unit, and $43.47 for the subsequent units.

For date of service May 14, 2019 the total is $624.19. The respondent paid $764.54. As a result additional reimbursement is not recommended.

For date of service July 29, 2019 the total is $363.40/each. The respondent paid $764.54. As a result, additional reimbursement is not 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

Signature	Medical Fee Dispute Resolution Officer	12/3/2020 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, 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 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 MDR 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.