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
DALLAS TESTING, INC

Respondent Name
XL SPECIALTY INSURANCE COMPANY

MFDR Tracking Number
M4-21-0816-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 20, 2021

Response Submitted By
Travelers Insurance Company

REQUESTOR'S POSITION SUMMARY

"The above date of service was not paid due to the following reason: Services not provided by network/primary care provider. The treating provider for this patient, Dr. James Mitchell, D.C., referred the patient to our provider to have the PHYSICAL PERFORMACE EVALUATION. Please see office visit note and referral attached."

RESPONDENT'S POSITION SUMMARY

"On 08-25-2020, the Claimant contacted the Carrier about changing Treating Doctors. The adjuster explained that since this would be the first change within 60 days of the date of injury, the Claimant could do so at her discretion. At that time, the Claimant indicated she wanted to think about the change before making a decision. On 08-31-2020, the Claimant again contacted the Carrier and confirmed that she wanted to change Treating Doctors to Elite Healthcare. The Carrier sent confirmation of the change request to the Claimant the same date. Apparently, the Claimant was concurrently treating with her personal physician, Dr. James Mitchell at Elite Healthcare. Dr. Mitchell ordered the testing performed by the Provider that is the subject of this Medical Fee Dispute Resolution Request. At the time the testing was ordered, however, Dr. Mitchell was neither the Treating Doctor nor a Referral Doctor. Therefore, the services at issue were not ordered by an authorized workers' compensation doctor. As the services were not ordered by an authorized provider, no reimbursement is due for the disputed services.
The Carrier contends the Provider is not entitled to additional reimbursement."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 10, 2020	CPT Code 97750-GP (X8) Physical Performance Evaluation	$483.36	$371.40

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 (TAC) §133.307 (TAC), effective May 31, 2012 sets out the procedures for resolving a medical fee dispute.
2. 28 TAC §134.600, sets out the preauthorization guidelines for specific treatments and services.
3. 28 TAC §137.100, sets out the use of the treatment guidelines.
4. 28 TAC §134.203, sets out the fee guidelines for reimbursement of professional medical services.
5. 28 TAC §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 code:
   - 119-Benefit maximum for this time period or occurrence has been reached.
   - 242-Services not provided by network/primary care providers.
   - 163-the charge for this procedure exceeds the unit value and/or the multiple procedure rules.
   - 5628- Concurrent treatment for the same condition.
   - 5647 & 5762-Services not provided or authorized by designated (network/primary care) providers.
   - 5682-Pre-authorization was not obtained prior to the service/procedure being rendered.

Issue(s)

1. Does this dispute contain a certified network issue?
2. Is the requestor entitled to reimbursement for CPT code 97750-GP rendered on August 10, 2020?

Findings

1. The insurance carrier denied the disputed services with denial reduction codes "242-Services not provided by network/primary care providers."

   The injured employee must be enrolled in the certified workers' compensation network and the certified workers' compensation network must be named on the explanation of benefits, per 28 TAC §133.240 (f) (15). Based on information maintained by the division, the injured employee is not enrolled in a worker's compensation health care network certified in accordance with Insurance Code Chapter 1305. The insurance carrier has not reported to the division that the injured employee was enrolled in certified workers' compensation health care network and has not provided any information to the DWC to support that the injured employee has been enrolled in such a network.

   28 TAC §133.240 (f) (15) requires that the insurance carrier shall include the "workers' compensation health care network name (if applicable)" on the paper form of an explanation of benefits. While the explanation of benefits does contain denial reason 242, its does not mention the health care network name on the paper form EOB, registered with the division as certified Texas workers' compensation health care networks established in accordance with Insurance Code Chapter 1305.

   Accordingly, based on the information presented to MFDR, the division finds that the insurance carrier has failed to meet the requirements of Rule §133.240 (f) (15). The insurance carrier thus failed to give plain language notice to the provider that a network was involved or that any special requirements were applicable and has therefore waived the right to assert that network provisions apply. The division concludes it has authority to review the fee issues in this dispute and will proceed to review them under applicable division rules and fee guidelines.

2. The requestor seeks medical fee dispute resolution in the amount of $483.36 for CPT code 97750-GP rendered on August 10, 2020.

   According to the explanation of benefits, the carrier denied payment for the disputed FCE based upon a lack of preauthorization.

   To determine if the requestor is eligible for reimbursement the DWC refers to the following statute:

   - 28 TAC §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.

- 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."

Review of the submitted documentation does not support that the requestor exceeded the number of test or the amount of time allowed per the fee guideline, the DWC finds the denial of payment for a lack of preauthorization is not supported. The requestor is therefore due reimbursement per 28 TAC §134.225 and §134.203.

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."

   On the disputed dates of service, the requestor billed CPT code 97550-FC (X8). 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 2020 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 75211 which is located in Dallas, Texas; therefore, the Medicare locality is "Dallas, Texas."
   - The Medicare participating amount for CPT code 97750 at this locality is $36.15 for the first unit, and $26.58 for subsequent units.

- The DWC conversion factor for 2020 is 60.32.
- The Medicare conversion factor for 2020 is 36.0896.
- 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 $60.42 for the first unit, and $44.43 for the subsequent units, for a total of $371.40. The respondent initially paid $0.00. The difference between MAR and amount paid is $371.40; this amount is recommended for reimbursement.

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 $371.40.

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 $371.40 plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		February 11, 2021
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 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 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 TAC §141.1(d).

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