TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
North Texas Pain Recovery Center

Respondent Name
Hartford Casualty Insurance Co.

MFDR Tracking Number
M4-21-2253-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
August 9, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 30, 2020	CPT Code 97750-FC (X8) Functional Capacity Evaluation (FCE)	$494.32	$365.60
	Total	$494.32	$365.60

Requestor's Position

"The FCE in question **is pursuant to the ODG and a required exam prior to utilization review of Division Return to Work programming, 'Chronic Pain Management'."**

October 12, 2021: "Evidence of loss of function is gathered by performing a 'functional capacity evaluation.'"

Amount in Dispute: $494.32

Respondent's Position

The Austin carrier representative for Hartford Casualty Insurance Co is Burns Anderson Jury Brenner. Burns Anderson Jury Brenner received a copy of this medical fee dispute on August 17, 2021. 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).

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.225 sets the reimbursement guidelines for FCEs.

3. 28 TAC §134.203 sets out the fee guidelines for professional services.

Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- 90409, 119-Benefit maximum for this time period or occurrence has been reached.
- 90950-This bill is a reconsideration of a previously reviewed bill. Allowance amounts reflect any changes to the previous payment.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

Issues

1. Is Hartford Casualty Insurance Company's denial based on reason code 45 supported?

2. Is Hartford Casualty Insurance Company's denial based on reason code 45 supported?

3. Is North Texas Pain Recovery Center entitled to reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $494.32 for CPT code 97750-FC (X8) rendered on September 30, 2020.

According to the explanation of benefits, the carrier reducedThe respondent denied payment for the disputed FCE based upon "45- Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement." A review of the submitted documentation finds that neither party to the dispute submitted a copy of the contractual agreement; therefore, the respondent's denial based upon reason code 45 is not supported.

2. The respondent also denied reimbursement for the disputed FCE based upon "90409, 119-Benefit maximum for this time period or occurrence has been reached." The respondent did not submit any documentation to support the requestor exceeded the fee guideline; therefore, the respondent's denial based upon reason codes 90409 and 119 is not supported.

3. The 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.

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.

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 76016 which is located in Arlington, Texas; therefore, the Medicare locality is "Fort Worth."
- The carrier code for Texas is 4412 and the locality code for Fort Worth is 28.
- The Medicare participating amount for CPT code 97750 at this locality is $35.48 for the first unit, and $26.18 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 $59.30 for the first unit, and $43.76 for the subsequent units, for a total of $365.60. The respondent paid $0.00. The difference between MAR and amount paid is $365.60.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement of $365.60 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Hartford Casualty Insurance Co. must remit to North Texas Pain Recovery Center $365.60 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		10/12/2021
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.