TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Dr. Troy O. Robinson

Respondent Name
Amerisure Mutual Insurance Co.

MFDR Tracking Number
M4-22-0246-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
October 5, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 10, 2021	CPT Code 97750-FC (X16) Functional Capacity Evaluation (FCE)	$967.84	$737.42
	Total	$967.84	$737.42

Requestor's Position

"WORK COMP TREATMENT AND SERVICES NO PAYMENT RECEIVED."

Amount in Dispute: $967.84

Respondent's Position

"Based on the evidence provided by Genesis medical this was not billed for an accepted/compensable injury. Furthermore, this claim is in the Texas First Health network and MDR is not the correct avenue for medical fee resolution.

Response Submitted by: Amerisure Insurance

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 denied the payment for the disputed services with the following claim adjustment codes:

- 219-Based on extent of injury.
- W3-Reporting Purposes Only Denial PLN 11.

Issues

1. Is Amerisure Mutual Insurance Company's denial based on reason code 219 supported?

2. Is Amerisure Mutual Insurance Company's position based on claim being in the Texas First Health network supported?

3. Is Dr. Troy O. Robinson entitled to reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $967.84 for CPT code 97750-FC (X16) rendered on February 10, 2021.

   According to the explanation of benefits, the carrier denied payment for the disputed FCE based upon "219-Based on extent of injury."

   28 TAC § 133.307(d) states, "Responses. Responses to a request for MFDR must be legible and submitted to the division and to the requestor in the form and manner prescribed by the division. (2) Response. On receipt of the request, the respondent must provide any missing information not provided by the requestor and known to the respondent. The respondent must also provide the following information and records: (H) If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier must attach any related Plain Language Notice in accordance with §124.2 of this title (concerning Insurance Carrier Reporting and Notification Requirements)."

A review of the submitted documentation finds the respondent did not submit a copy of the PLN 11 to support compliance with 28 TAC §133.307 and 124.2. Therefore, the respondent's denial of payment for the disputed services based upon reason code 219 is not supported.

2. The respondent states in the position summary that "this claim is in the Texas First Health network and MDR is not the correct avenue for medical fee resolution."

   28 TAC § 133.307(d) states, "Responses. Responses to a request for MFDR must be legible and submitted to the division and to the requestor in the form and manner prescribed by the division. (2) Response. On receipt of the request, the respondent must provide any missing information not provided by the requestor and known to the respondent. The respondent must also provide the following information and records: (F) The responses shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. "

   A review of the submitted documentation does not support the respondent presented the network issue to the requestor prior to the date the request for MFDR was filed. The respondent did not submit documentation to support the claim was in network to support this position; therefore, the network issue is not supported and will not be considered further in the review.

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 (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 2021 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 78752 which is located in Austin, Texas; therefore, the Medicare locality is "Austin, Texas."
- The carrier code for Texas is 4412 and the locality code for Austin, Texas is 31.
- The Medicare participating amount for CPT code 97750 at this locality is $35.29 for the first unit, and $25.69 for subsequent units.

The DWC conversion factor for 2021 is 61.17

The Medicare conversion factor for 2021 is 34.8931.

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 $61.87 for the first unit, and $45.04 for the subsequent units, for a total of $737.42. The respondent paid $0.00. The difference between MAR and amount paid is $737.42; this amount is recommended for reimbursement.

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 $737.42 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 Amerisure Mutual Insurance Co. must remit to Dr. Troy O. Robinson $737.42 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		11/02/2021
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.