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

General Information

Requestor Name
PEAK INTEGRATED HEALTHCARE

Respondent Name
HARTFORD UNDERWRITERS INSURANCE COMPANY

MFDR Tracking Number
M4-22-1156-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
February 15, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 23, 2021	97750-FC x 8 units	$482.16	$377.44
	Total	$482.16	$377.44

Requestor's Position

"The above date of service was not paid due to the following reason: 'Precertification/ authorization/notification absent; AND 'This provider is not an authorized provider.' This is incorrect. This provider is an authorized treater in workers' compensation. The treating doctor referring the patient to our provider to have the PHYSICAL PERFORMACE EVALUATION. Please See office visit note and referral attached. I am resubmitting this medical bill because the fee schedule allows for $482.16 to be charged for PHYSICAL PERFORMANCE EVALUATION that lasts 2 hours (8 units). The Maximum Allowable Reimbursement {MAR) for Workers' Compensation is configured by the Conversion Factor {which is a combination of the Medicare and DWC Conversation Factors.) multiplied by the Participating Provider fee. Please see attached fee schedule. The charge does not exceed the fee schedule."
Amount in Dispute: $482.16

Respondent's Position

"Bill was process under control number… on 1/27/22 and denied as not authorized per the adjuster's instructions: do not pay no auth."
Response Submitted by: The Hartford

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 (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 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.
3. 28 TAC §134.600 sets out the guidelines for Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
4. 28 TAC §134.210, effective July 7, 2016, sets out the medical fee guideline for workers' compensation specific services in the Texas workers' compensation system.
5. 28 TAC §134.225, effective July 7, 2016, sets the reimbursement guidelines for FCEs.
6. 28 TAC §134.235, effective July 7, 2016, sets the reimbursement guideline for return to work/evaluation of medical care.

Denial Reasons

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

- 133 – The disposition of this claim/service is pending further review.
- AUTH – Payment denied/reduced for absence of or exceeded precertification/ authorization. Preauthorization was not obtained, and treatment was rendered without the approval of treating doctor.
- PPRJ – Paid without prejudice.
- 96 – Non covered charge(s).
- APPR – Reimbursement is being withheld as the treating doctor and/or services rendered were not approved based upon handler review.

Issues

1. Is the Insurance Carrier's denial reason(s) supported?
2. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 97750-FC rendered on September 23, 2021. The insurance carrier denied/reduced the service in dispute with reduction codes 133, AUTH, PPRJ, 96 and APPR, (descriptions provided above.)

   The insurance carrier states in pertinent part, "Bill was process under control number… on 1/27/22 and denied as not authorized per the adjuster's instructions: do not pay no auth."

28 TAC §134.600 (p)(1-12) outlines the health care that requires preauthorization. An FCE is not an item listed in 28 TAC 134.600. As a result, the DWC finds that preauthorization was not required for CPT Code 97750-FC.

28 TAC §134.210(b) states, "Payment policies relating to coding, billing, and reporting for workers' compensation specific codes, services, and programs are as follows: (2) Modifying circumstance shall be identified by use of the appropriate modifier following the appropriate Level I (CPT codes) and Level II HCPCS codes. Where HCPCS modifiers apply, insurance carriers shall treat them in accordance with Medicare and Texas Medicaid rules. Additionally, division-specific modifiers are identified in subsection (e) of this section…"

CPT code 97750 is described as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes." The requestor appended modifier "FC" to code 97750.

28 TAC §134.210(e) states, "The following division modifiers shall be used by health care providers billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes. (3) FC, functional capacity--This modifier shall be added to CPT code 97750 when a functional capacity evaluation is performed."

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 DWC finds that preauthorization is not required for an FCE, and therefore the requestor is entitled to reimbursement.

2. 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…"

   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 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 75043 which is located in Garland, Texas; therefore, the Medicare locality is "Dallas, Texas."
- The Medicare participating amount for CPT code 97750 at this locality is $35.06 for the first unit, and $25.75 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 $61.46 for the first unit, and $45.14 x 7 units = $315.98 for the subsequent units, for a total of $377.44. The respondent paid $0.00. The difference between the MAR and amount paid is $377.44; this amount is recommended for reimbursement.

The DWC finds that the requestor is entitled to reimbursement in the amount of $377.44

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.

The DWC finds the requester has established that reimbursement of $377.44 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor $377.44 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		March 16, 2022
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.