



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Amanda McInis

Respondent Name

United States Fire Insurance Co

MFDR Tracking Number

M4-22-2145-01

Carrier's Austin Representative

Box Number 53

DWC Date Received

May 31, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 8, 2021	CPT Code 97750-FC	\$523.48	\$383.37
Total		\$523.48	\$383.37

Requestor's Position

"...The provider has no contracted/legislated fee arrangement for this DWC specific code and should be paid according to the Maximum Allowable Reimbursement per Division Rule 134.402 and not subject to pre-authorization. Billing submitted was for \$587.04 for a 9 unit test and that includes the DWC-73 form, however, our records showed the examinee did have an initial exam in 2020 and the DWC Rule 134.202 only allows the second FCE to be paid at a maximum of 8 units, plus the DWC-73 form. Our bill was corrected and submitted as per the email response from the carrier had indicated us to do. The bill was reduced to \$523.48 per the allowed fee guideline Rule 134.204(g) details the required elements when conducting a functional capacity evaluation (FCE). Medicare payment policies using the Division CF as described in the "Calculating the MAR" section of this module, apply to billing and reimbursement for FCEs."

Amount in Dispute: \$523.48

Respondent's Position

"Carrier responds that it is in the process of paying the requestor the amount in dispute."

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 §134.600 sets out requirements of prior authorization.
3. 28 TAC §134.225 sets the reimbursement guidelines for FCEs.
4. 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:

- W3 – Bill is a reconsideration or appeal
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted
- 5599 – Preauthorization not sought or obtained. Services denied for non-authorization

Issues

1. Is the respondent's position summary supported?
2. Is the insurance company's denial based on lack of pre-authorization supported?
3. What rule is applicable to DWC fee guideline?
4. Is the requestor entitled to payment?

Findings

1. The respondent states in their position statement, "Carrier responds that it is in the process of paying the requestor the amount in dispute." Review of the submitted documentation

found insufficient evidence to support a payment of the disputed service was made. The service in dispute will be reviewed per applicable DWC specific rule(s) and fee guideline.

2. The requestor is seeking medical fee dispute resolution in the amount of \$523.48 for CPT code 97750-FC for eight units rendered June 8, 2021.

The insurance carrier denied the disputed service based on lack of pre-authorization. DWC Rule 28 TAC 134.600 (p) lists services that require prior authorization. Review of the submitted medical bill and documentation found insufficient evidence to support the disputed services required prior authorization. The insurance carrier's denial is not supported the disputed service will be reviewed be applicable fee guideline.

3. The fee guideline for FCEs is found at 28 TAC §134.225.

DWC Rule 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. "

DWC Rule 28 TAC §134.203(c)(1) states in pertinent part, 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 conversion factor of applicable date of service.

On the disputed dates of service, the requestor billed CPT code 97550-FC for eight units as a reconsideration. The *Medicare Claims Processing Manual Chapter 5, 10.3.7, titled Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services*, states:

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.

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 77022 which is Houston, Texas; therefore, the Medicare locality is Houston.

The carrier code for Texas is 4412 and the locality code for Houston is 18.

- The Medicare participating amount for CPT code 97750 at this locality is \$35.50 for the first unit, and \$26.17 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 \$62.23 for the first unit, and \$321.14 for the subsequent units, for a total of \$383.37. 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 \$383.37 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 United States Dire Insurance Co. must remit to Amanda McInis \$383.37 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	_____	August 2, 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 electrónico CompConnection@tdi.texas.gov.