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

General Information

Requestor Name
Gulf Coast Functional Testing

Respondent Name
Hartford Casualty Insurance Co

MFDR Tracking Number
M4-22-2632-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
August 17, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 2, 2021	97750 FC GP	$600.00	$367.04
	Total	$600.00	$367.04

Requestor's Position

"Code 97750 FC GP does not require prior authorization according to TDI rules and regulations."

Amount in Dispute: $600.00

Respondent's Position

"The bill in question was processed and denied as not authorized on 11/30/21 under control number 217347493 per the adjuster's response. The FCE was not approved."

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 §133.307 (TAC) sets out the procedures for resolving a medical fee dispute.

2. 28 TAC §134.600, requires preauthorization for specific treatments and services.
3. 28 TAC §137.10, sets out the use of the treatment guidelines.
4. 28 TAC §137.100 sets out administrative process for retrospective review.
5. 28 TAC §19.2003 defines retrospective review.
6. 28 TAC §19.2015 sets our notification requirement and opportunity to appeal.
7. 28 TAC §134.225 sets the reimbursement guidelines for FCEs.
8. 28 TAC §134.203 sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.

Denial Reasons

The insurance carrier denied the disputed service with the following claim adjustment codes.

- 96 – Non-covered charge(s)
- NABA – Reimbursement is being withheld as the treating doctor and/or services rendered were not approved based upon handler review.
- 133 – The disposition of this claim/service is pending further review
- Auth – Payment denied/reduced for absence of or exceeded, pre-certification/authorization. Pre-authorization was not obtained and treatment was rendered with the approval of treating doctor. If you require additional information regarding this bill decision. Contact claim handler.

Issues

1. Does the disputed service require prior authorization?
2. Did the carrier follow the appropriate administrative process to address the assertions made in its response to medical fee dispute?
3. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking medical dispute resolution for CPT code 97750-FC rendered in November 2021. The insurance carrier denied for lack of prior authorization.

   DWC Rule 28 TAC §134.600(p)(12) states in pertinent part preauthorization is required 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.

According to the Fitness for Duty Chapter of the Official Disability Guidelines (ODG), an FCE is a recommended treatment. No prior authorization is required.

2. The insurance carrier included the statement "…per the adjuster's response. The FCE was not approved."

   DWC rule 28 TAC §137.100 (e) sets out the appropriate administrative process for the carrier to retrospectively review reasonableness and medical necessity of care already provided. Section (e) states:

   "An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017."

   Retrospective review is defined in 28 TAC §19.2003 (28) as "The process of reviewing health care which has been provided to the injured employee under the Texas Workers' Compensation Act to determine if the health care was medically reasonable and necessary."

   DWC Rule 28 TAC §19.2015(b) titled Retrospective Review of Medical Necessity states: (b) When retrospective review results in an adverse determination or denial of payment, the utilization review agent shall notify the health care providers of the opportunity to appeal the determination through the appeal process as outlined in Chapter 133, Subchapter D of this title (relating to Dispute and Audit of Bills by Insurance Carriers)."

   The division finds that the carrier failed to follow the appropriate administrative process to address the assertions made in its response to this medical fee dispute. The disputed service will be reviewed per applicable fee guideline.

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

   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 requestor did not support that the disputed FCE were ordered by the division; therefore, the limits listed above apply.

   The documentation included with the request for MFDR indicates a prior FCE was performed on October 15, 2021. This is an interim test. Per 28 TAC §134.225 the maximum for an interim test is two hours.

DWC Rule 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 conversion factor for date of service listed on the medical bill in dispute.

The applicable Medicare payment policy is found in the *Medicare Claims Processing Manual* Chapter 5, 10.3.7 titled *Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services*.

Full payment is made for the unit or procedure with the highest PE payment. 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 77076, Houston, Texas.
- 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 $45.88 for the subsequent 7 units, for a total of $45.88 + $321.16 = $367.04. 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 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 respondent must remit to requestor $367.04 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 13, 2022 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.