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
GULF COAST FUNCTIONAL TESTING

Respondent Name
PROPERTY & CASUALTY INSURANCE CO.

MFDR Tracking Number
M4-23-0320-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
October 7, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 11, 2021	97750-FC-GP x 7 units	$525.00	$337.50
	Total	$525.00	$337.50

Requestor's Position

"The treating doctor recommended the services. We provided the carrier with the prior authorization letter. We feel that our facility should be paid according to the workers compensation fee schedule guidelines."

Amount in Dispute: $525.00

Respondent's Position

"Please accept this letter as a response to the above dispute. The bill in question was processed on 11/30/21 and denied as not authorized per adjuster's instructions: The '3 FCE's without auth' has changed. Now all FCE's have to be prior auth'd. If you do not agree, please file a request for hearing or a medical fee dispute,"

Response Submitted by: 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 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.225, effective July 7, 2016, sets the reimbursement guidelines for FCEs.

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. If you require addition information regarding this bill, contact the claim handler.
- PPRJ – Paid without prejudice.
- 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. If you require additional information regarding this bill decision, contact the claim handler.

Issues

1. Is the Insurance Carrier's denial reason supported?
2. Is the Requestor entitled to reimbursement for CPT Code 97750-FC?

Findings

1. The requestor seeks reimbursement for CPT Code 97750-FC rendered on November 11, 2021. The insurance carrier denied/reduced the disputed service due to lack of preauthorization.

   28 TAC §134.203(b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   CPT Code 97750-FC is defined as a functional capacity evaluation.

2. The applicable 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. "

The DWC finds the respondent did not support the requestor exceeded the fee guideline by the number of tests; therefore, the respondent's denial based upon the fee guideline is not supported.

The DWC also finds, that preauthorization is not required for the FCEs. The injured employee is allowed three FCEs for each compensable injury. The insurance carrier submitted insufficient information to support that the requestor exceeded the three FCEs for this injury. As a result, the insurance carrier's denial reasons are not supported and the requestor is entitled to reimbursement for CPT Code 97750-FC.

3. 28 TAC §134.203 states in pertinent part, "(c) 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. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) 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..."

   On the disputed dates of service, the requestor billed CPT code 97550-FC (x 7). The multiple procedure rule discounting applies to the disputed service.

   Medicare Claims Processing Manual Chapter 5, 10.7-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.

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

- MPPR rates are published by carrier and locality.
- The disputed date of service was rendered in 2021.
- The 2021 DWC Conversion Factor is 61.17
- The 2021 Medicare Conversion Factor is 34.8931
- Per the medical bills, the services were rendered in zip code 77076; therefore, the Medicare locality is "Houston."
- The Medicare participating amount for CPT code 97750 at this locality is $35.50 for the first unit, and $26.17 for subsequent units.
- Using the above formula, the DWC finds the MAR is $62.23 for the first unit, and $45.88 x 6 = $275.27 for the subsequent 6 units = a total MAR of $337.50.
- The respondent paid $0.00.
- Reimbursement of $337.50 is recommended.

4. The DWC finds that the requestor has established that reimbursement of $337.50 is due As a result, this amount is recommended.

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 $337.50 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 $337.50 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		December 12, 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.