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
Simon J. Forster, D.C.

Respondent Name
Arch Indemnity Insurance Co.

MFDR Tracking Number
M4-23-0658-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
November 15, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 25, 2022	Functional Capacity Evaluation 97750-FC	$1,179.84	$752.85

Requestor's Position

You are in error for denying reimbursement for code 97750-FC by **incorrectly** applying CCI edits to exclusive Division of Work Comp (DWC) commission-specific, proprietary codes which are govered by TAC rule and **ARE NOT SUBJECT TO CCI EDITS** …

The 99456 W5 WP RE W8 (MMI/IR/RTW exam) is a DWC-specific, proprietary evaluations that serves a dispute-resolution purpose by answering questions of MMI and impairment status, with specific code performance requirements outline and defined by rule with proprietary protocols and reimbursement. Opinion includes the *determination/incorporation of what further tests are required*. ***Any Additional testing is performed separately to the exam, and not as a component of the exam***.

Subsequent Response:

The carrier is making the incorrect argument that the 97750-FC code is a sub-component of 98956-W5NM and 99456-REW8 and thus not reimbursable when used in conjunction, making the assertion that 99456-W5NM and 99456 REW8 together with 97750-FC are 'unbundled

procedures'.

Amount in Dispute: $1,179.84

Respondent's Position

The provider was appointed on the issues of MMI, impairment rating and ability to return to work. The provider billed for the MMI portion of the exam but also billed for a functional capacity evaluation. It is the carrier's position that the provider is not entitled to reimbursement for the FCE …

In addition to the CMS-1500 and the EOBs, they are attaching a copy of the document entitled EncoderPro.com expert. That document discusses the situations in which there is a CCI conflict between CPT codes 99456 and 97750. Those are the two CPT codes billed in this case. The provider is not entitled to reimbursement for CPT code 97750.

Subsequent Response:

We are attaching a medical fee dispute resolution finding and decision dated April 22, 2022, on essentially the same issue as the current medical fee dispute … In that case, the provider billed under CPT code 99456-W5 and also billed for a functional assessment. By analogy, the provider in the current case is not entitled to any reimbursement for the functional assessment.

Response Submitted by: Flahive, Ogden & Latson

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 §127.10 provides the general procedures for designated doctor examinations.

2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

3. 28 TAC §134.203 sets out the fee guidelines for professional services.

4. 28 TAC §134.225 sets out the fee guidelines for functional capacity evaluations.

5. 28 TAC §134.235 sets out the fee guidelines for examinations to determine the extent of the compensable injury.

Denial Reasons

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

- 97
- 906 – In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor), component code of comprehensive medicine, evaluation and management services procedure (90000-99999) has been disallowed.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is Arch Indemnity Insurance Co.'s denial based on CCI edits supported?

2. Is Simon J. Forster, D.C. entitled to additional reimbursement?

Findings

1. Dr. Forster is seeking additional reimbursement for four hours (16 units) of a functional capacity evaluation (FCE) performed on August 25, 2022, in conjunction with a designated doctor examination.

   Arch Indemnity Insurance Co. denied payment stating, "In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor), component code of comprehensive medicine, evaluation and management services procedure (90000-99999) has been disallowed."

   While Dr. Forster failed to bill for the examination to determine the ability of the injured employee to return to work, the examination was requested and noted as performed with required documentation. Per §127.10 (c), a designated doctor is required to perform or refer for additional testing when it is necessary to resolve the issue in question. 28 TAC §134.235 provides for payment of additional testing when performed in conjunction with examinations regarding ability to return to work.

   Dr. Forster billed for the functional capacity evaluation using procedure code 97750 and modifier "FC." This indicates division-specific billing that is not subject to Medicare's NCCI edits. The insurance carrier's denial of payment is not supported.

2. Because the insurance carrier failed to support its denial of payment, DWC finds that Dr. Forster is entitled to reimbursement for the examination in question.

   Per 28 TAC §134.225, reimbursement for billing code 97750-FC shall be up to a maximum of four hours for a division ordered test and shall be paid in accordance with 28 TAC §134.203.

   28 TAC §134.203 (c) states:

   (c) To determine the MAR for professional services, system participants shall apply the

Medicare payment policies with minimal modifications.

(1) For service categories of … Physical Medicine and Rehabilitation, … the established conversion factor to be applied is $52.83 …

(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.

The workers' compensation conversion factor for 2022 is $62.46.

134.203 (b) states:

(b) 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.

The Medicare Annual Therapy Update states, in relevant part:

Section 1834(k)(5) of the Act requires that all claims for outpatient rehabilitation therapy services and all comprehensive outpatient rehabilitation facility (CORF) services be reported using a uniform coding system. The current Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) is used for the reporting of these services … The Medicare Physician Fee Schedule (MPFS) is used to make payment for these therapy services at the nonfacility rate.

Medicare Claims Processing Manual Chapter 5 - Part B states, in relevant part:

Medicare applies an MPPR to the PE payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure … 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.

For date of service August 25, 2022, procedure code 97750, performed in Austin, Texas:

- The work total is 0.45;
- The practice expense total is 0.55068 for the first unit, and 0.27534 for subsequent units;
- The malpractice total is 0.01078.

The sum of these for the first unit is 1.01146 and for subsequent units is 0.73612. These totals are multiplied by the DWC conversion factor of $62.46. The total allowable for 16 units is $752.85. 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.

DWC finds the requester has established that additional reimbursement of $752.85 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 Arch Indemnity Insurance Co. must remit to Simon Forster, M.D. $752.85 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		January 24, 2023
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.