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
XL INSURANCE AMERICA INC.

MFDR Tracking Number
M4-23-0761-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
November 28, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 21, 2022	97750-FC-GP	$300.00	$204.06
	Total	$300.00	$204.06

Requestor's Position

"The treating doctor recommended the services. We feel that our facility should be paid according to the workers compensation fee schedule guidelines."

Amount in Dispute: $300.00

Respondent's Position

"The original request submitted by Gulf Coast Functional Testing on August 10, 2022, was denied due to no pre-authorization submitted to Utilization Review for the date of service. Gulf Coast Functional Testing submitted a request for reconsideration and the denial of payment was upheld again for, 'absence of precertification/authorization.' "

Response Submitted by: Ricky D. Green, PLLC

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 sets out the fee guideline for professional medical services.
3. 28 TAC §134.600, sets out the preauthorization guidelines for specific treatments and services.
4. 28 TAC §137.100, sets out the use of the treatment guidelines.
5. 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:

- 5721 - TO AVOID DUPLICATE BILL DENIAL FOR ALL RECONSIDERATIONS/ ADJUSTMENTS/ ADDITIONAL PAYMENT REQUESTS SBMIT A COPY OF THIS EOR OR CLEAR NOTATION THAT A RECON...
- 90438 & 197 - PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/ AUTHORIZATION.
- 3284 - NOT ALL DOS HAVE BEEN AUTHORIZED.
- 90563 & 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 90950 – THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL; ALLOWANCE AMOUNTS REFLECT ANY CHANGES THE PREVIOUS PAYMENT.

Issues

1. Is the Insurance Carrier's denial reason for lack of preauthorization supported?
2. Do the disputed services contain NCCI edit conflicts that may affect reimbursement?
3. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 97750-FC-GP rendered on July 21, 2022. According to the explanation of benefits, the carrier denied payment for the disputed FCE based upon a lack of preauthorization.

   To determine if the requestor is eligible for reimbursement the DWC refers to the following:

   - 28 TAC §134.600(p)(12), requires preauthorization 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. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits)."

- According to the Fitness for Duty Chapter of the Official Disability Guidelines (ODG), an FCE is a recommended treatment.
- 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."

Review of the submitted documentation does not support that the requestor exceeded the number of test or the amount of time allowed per the fee guideline, the DWC finds the denial of payment for a lack of preauthorization is not supported. The requestor is therefore due reimbursement per 28 TAC §134.225 and §134.203.

2. 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."

On the disputed dates of service, the requestor billed CPT code 97550-FC (x 4). 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 2022 services is found at https://www.cms.gov/Medicare/Billing/TherapyServices/index.html. The MPPR rates are published by carrier and locality.

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…"

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

- Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 77076 which is located in "Houston, Texas"; therefore, the Medicare locality is "Houston."
- The Medicare participating amount for CPT code 97750 at this locality is $35.21 for the first unit, and $25.95 for subsequent units.
- The DWC conversion factor for 2022 is 62.46.
- The Medicare conversion factor for 2022 is 34.6062.
- 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 $63.55 for the first unit, and $46.84 for the subsequent units, for a total of $140.51, the MAR is therefore, $204.06. The respondent paid $0.00. The difference between MAR and amount paid is $204.06; 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.

The DWC finds the requester has established that reimbursement of $204.06 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 $204.06 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		March 21, 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.