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
Marcus Hayes, D.C.

Respondent Name
Hanover American Ins. Co.

MFDR Tracking Number
M4-23-0842-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
December 10, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 18, 2022	97750-FC, 9 units	$113.26	$0.00
	TOTAL	$113.26	$0.00

Requestor's Position

"As stated in my request for reconsideration: 1. Page 2 clearly indicates that the exam was 2 hours and 10 mins which indicates 9 units which was billed... The 10/18/2022 FCE was the third FCE and therefore, up to three hour (12 units) are allowed. In this particular case, 9 units were billed which is within the allowed fee schedule. Therefore, the reduction in payment based on the above codes are invalid."

Amount in Dispute: $113.26

Respondent's Position

The Austin carrier representative for Hanover American Insurance Co. is JT Parker & Associates, LLC. The representative was notified of this medical fee dispute on December 20, 2022. Per 28 TAC §133.307 (d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information. As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

Response Submitted by: N/A

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 §134.225 sets the reimbursement guidelines for Functional Capacity Evaluations (FCE).

Adjustment Reasons

The insurance carrier reduced the payment for the disputed service with the following claim adjustment codes:

- P12 – The charge for this procedure exceeds the amount indicated in the fee schedule.
- 151 – The charge exceeds the scheduled value and/or a time parameter that would appear reasonable.
- 45 - A PPO reduction was made for this bill and/or the bill was repriced according to a negotiated rate.
- YO(P12) – Denial after reconsideration.

Issues

1. Is the insurance carrier's reimbursement reduction reason supported?
2. Is Marcus Hayes, D.C. entitled to additional reimbursement for 9 units of CPT code 97750-FC rendered on October 18, 2022?

Findings

1. The insurance carrier reduced the payment allowed citing reason codes described above.

   Regarding reason codes P12 and 151, 28 TAC §134.225 states in pertinent part, "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, in its position statement, states that the FCE rendered on October 18, 2022, was the third FCE for this injured worker. However, a review of the medical record submitted finds that the documentation does not indicate that the FCE in dispute was a discharge FCE. Therefore, in accordance with 28 TAC §134.225, a maximum of two hours (8 units) was allowed for a FCE that is not either the initial evaluation or the discharge evaluation.

DWC finds that the insurance carrier's reimbursement reduction reasons based on charges exceed reasonable time parameter and fee schedule, is supported.

Regarding the PPO reduction stated on the explanation of benefits, according to the submitted documentation and information known to DWC, there is no evidence to support that the service in dispute is a network claim. Therefore, DWC finds that a PPO reduction reason is not supported and that DWC has jurisdiction to adjudicate this medical fee dispute.

2. Dr. Hayes is seeking additional reimbursement for a functional capacity evaluation (FCE) performed on October 18, 2022. The examination is identified as a division-specific service with billing code 97750-FC.

   28 TAC §134.225 states: "The following applies to functional capacity evaluations (FCEs) … 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."

   Per 28 TAC §134.203 (b)(1), parties are required to apply Medicare payment policies, including its coding, billing, correct coding initiatives (CCI) edits, modifiers, and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules to workers' compensation coding, billing, reporting, and reimbursement of professional medical services.

   28 TAC §§134.203 (a)(7) and 134.210 (a) state that specific provisions contained in the Texas Labor Code or division rules shall take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program. However, no such conflict regarding billing or reimbursement was found that applies to a division-specific functional capacity evaluation. Therefore, Medicare reimbursement rules are applied to the examination in question.

   Per Medicare Claims Processing Manual (cms.gov), Chapter 5, 10.7, effective February 6, 2019:

   > Medicare applies a multiple procedure payment reduction (MPPR) to the practice expense (PE) payment of select therapy services. The reduction applies to the HCPCS codes contained on the list of "always therapy" services …
   >
   > Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure …
   >
   > 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.

Procedure code 97750 is classified as "always therapy" in the 2022 Therapy Code List and Dispositions found in the Annual Therapy Update | CMS and has a value of "5" on the MFSD. Therefore, the MPPR applies to the reimbursement of this code.

On the disputed date of service, October 18, 2022, the requestor billed CPT code 97750-FC X 9 units. However, as discussed in finding number 1, in accordance with 28 TAC §134.225, DWC finds that 8 units are supported as allowable per the medical record documentation. Therefore, the service in dispute will be adjudicated for 8 units of CPT code 97750-FC.

As described above, the multiple procedure discounting rule applies to the disputed service.

The MPPR Rate File that contains the payments for 2022 services is found at https://www.cms.gov/Medicare/Billing/TherapyServices/index.html.

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

- MPPR rates are published by carrier and locality.
- The disputed date of service is October 18, 2022.
- The disputed service was rendered in zip code 77581, locality 09, carrier 4412.
- The Medicare participating amount for CPT code 97750 in 2022 at this locality is $34.86 for the first unit, and $25.66 for 7 subsequent units.
- The 2022 DWC Conversion Factor is 62.46
- The 2022 Medicare Conversion Factor is 34.6062
- Using the above formula, the DWC finds the MAR for 8 units of 97750-FC on the disputed date of service is $387.11.
- The respondent paid $396.40.
- No additional reimbursement is recommended.

DWC finds that the requestor has not established that additional reimbursement is due.

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 that no additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 additional reimbursement for the disputed service.

Authorized Signature

		December 15, 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.