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

General Information

Requestor Name
BRANDON COBY MARROW, PT, MPT

Respondent Name
INDEMNTIY INSRUANCE COMPANY

MFDR Tracking Number
M4-23-1195-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
January 25, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 13, 2022	97750-FCE	$168.58	$0.00
	Total	$168.58	$0.00

Requestor's Position

"I have appealed it twice because the first time we were only paid for 1 of the 12 units billed. We received additional money for the first appeal, but it was short the amount due to us… I am requesting the additional money due to use to be paid for the discharge FCE."

Amount in Dispute: $168.58

Respondent's Position

"The Carrier has paid a total of $547.70 for the FCE per the fee guidelines. In conclusion, Requestor is not owed any additional reimbursement for the FCE as the proper amount was paid per the fee guidelines."

Response Submitted by: Downs Stanford, P.C.

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

Denial Reasons

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

- 309 – The charge for this procedure exceeds the fee schedule allowance.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- N600 – Adjusted based on the applicable fee schedule for the region in which the service was rendered.
- 1002 – Due to an error in processing the original bill we are recommending further payment be made for the above noted procedure.
- 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules.
- 2008 – Additional payment made on appeal/reconsideration.
- 119 – Benefit maximum for this period or occurrence has been reached.

Issues

1. Does the Multiple Procedure Payment Reductions (MPPR) apply to CPT Code 97750-FC?
2. Is the Requestor entitled to additional reimbursement for CPT Code 97750-FC?

Findings

1. The requestor seeks additional reimbursement for CPT Code 97750-FC rendered on December 13, 2022. The insurance carrier issued payments totaling $547.70, and reduced the remaining billed amount with the denial reasons indicated above. The requestor seeks an additional payment tin the amount of $168.58.

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

   The applicable fee guideline for FCEs is found at 28 TAC §134.225 and 28 TAC §134.203.

   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. "

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."

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).
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> 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.
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> 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.

On the disputed dates of service, the requestor billed CPT code 97550-FC x (12 units). The DWC finds that the MPPR applies to the disputed service.

2. 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 (12 units). Reimbursement is determined as follows.

   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 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 2022.
- The 2022 DWC Conversion Factor is 62.46
- The 2022 Medicare Conversion Factor is 34.6062
- The Medicare participating amount for CPT code 97750 at this locality is $33.16 for the first unit, and $24.57 for subsequent units.
- Using the above formula, the DWC finds the MAR is $59.85 for the first unit and $44.35 for the subsequent units for a total MAR of $547.65.
- The respondent paid $547.70.
- Reimbursement of $0.00 is recommended.

The DWC finds that the requestor has not established that additional reimbursement is due As a result, $0.00 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 not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

		May 1, 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.