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

General Information

Requester Name
Peak Integrated Healthcare

Respondent Name
Hartford Casualty Insurance Co.

MFDR Tracking Number
M4-23-1337-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
February 8, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
12/13/2022	97750-FC	$502.08	$385.44
01/05/2023	99080-73	$15.00	$15.00
01/05/2023	99213	$174.72	$0.00
	Total:	$691.80	$400.44

Requestor's Position

Regarding 12/13/2023: "The above date of service was not paid due to the following reason: 'PENDING FURTHER REVIEW'. This is incorrect. This patient has received payment for these same codes on previous visits, see attached. This patient has only had 2 other FCE that has been paid. DWC rule 134.204(g) A maximum of 3 FCEs for each compensable injury shall be billed and reimbursed… "
Regarding 01/05/2023: "The above date of service was denied full payment stating 'EXCEEDS FEE ALLOWANCE'. This is incorrect. There was a previous office visit on 12/8/2022 that was paid in full.
The patient is entitled to reasonable medical care as stipulated in Texas law as related to the original injury. Office visits are recommended as determined to be medically necessary…"
Amount in Dispute: $691.80

Respondent's Position

"The bills in question were previously processed date of service (DOS) 12/13/22 on 12/26/22 under control number… 97750-Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes… subsequent encounter, Denial code:

96-non-covered charges, NABA - not approved based on handler review. This should have been denied for no prior auth- outside ODG. DOS 1/5/23 previously denied 1/13/23 under… was reprocessed on 2/23/23 under… and paid per adjuster instructions,… Denial code: CONT being withheld further investigation. This bill was not sent to handler to review. This bill is ok to pay…"
Response Submitted by: The Hartford 2/24/2023

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 FCEs.
4. 28 TAC §129.5 sets out the fee guidelines for the DWC73 reports.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:
Regarding 12/13/2022 DOS:

- 133 – The disposition of this claim/ service is pending further review.
- CONT – Payment is being withheld pending further investigation of compensability or treatment.
- PPRJ – Paid without prejudice.
- 96 – Non-covered charges.
- NABA – Reimbursement is being withheld as the treating doctor and/or services rendered were not approved based upon handler review.
- 247 – A payment or denial has already been recommended for this service.

Regarding 01/05/2023 DOS:

- W3 – Bill is a reconsideration or appeal.
- 309 – Charge for this procedure exceeds the fee schedule allowance.
- P12 – Workers' Compensation Jurisdictional fee schedule adjustment.
- 1002 – Due to an error in processing the original bill, we are recommending further payment be made for the above noted procedure.
- 2008 – Additional payment made on appeal / reconsideration.

Issues

1. Does the respondent's position statement address only the denial reasons presented to the requester prior to the date the request for medical fee dispute resolution (MFDR) was filed?
2. Is the Insurance Carrier's reimbursement denial reason(s) supported?
3. Is the Requester entitled to reimbursement for CPT code 97750-FC?
4. Is requester entitled to additional reimbursement for CPT code 99213?
5. Is requester entitled to reimbursement for Work Status Report 99080-73?

Findings

1. Regarding denial of 97750-FC, the insurance carrier (IC) in the position summary states, "…This should have been denied for no prior auth-…"

   28 TAC §133.307(d)(2)(F) states "The response shall address only those denial reasons presented to the requester prior to the date the request for medical fee dispute resolution (MFDR) was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

   The division finds that the respondent submitted a position summary containing new denial reasons and defenses. The additional denial reasons identified on the position summary, are not denial reasons raised during the medical bill review process, as they are not indicated on the Explanation of Benefits presented with the DWC060 request. The respondent submitted insufficient information to MFDR to support that the submitted denial reasons raised in their position summary were presented to the requester or that the requester had otherwise been informed of these new denial reasons or defenses prior to the date that the request for medical fee dispute resolution was filed with the DWC; therefore, the division concludes that the respondent has waived the right to raise such additional denial reasons or defenses.

2. The insurance carrier denied the disputed service, 97750-FC, with denial reasons indicated above.

   The division finds that the denial reason based on "further review of compensability" is not supported by a Plain Language Notice (PLN) as is required in accordance with (TAC) §133.307(d)(2)(H) which states "If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier must attach any related Plain Language Notice in accordance with §124.2 of this title (concerning Insurance Carrier Reporting and Notification Requirements)."

   The division finds that the denial reason based on "non-covered service" is also not supported in accordance with 28 TAC §134.225 quoted below in finding #3.

3. The requester is seeking reimbursement in the amount of $502.08 for 8 units of CPT code 97750-FC rendered on December 13, 2022.

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

   The applicable fee guideline for FCEs is found at 28 TAC §134.225, which 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) 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 submitted documentation finds that the requester documented and billed for a 2-hour FCE in compliance with 28 TAC §134.225. The division finds that the requester is entitled to reimbursement for 8 units of CPT code 97750-FC rendered on December 13, 2022.

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 in pertinent part:

> 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.
>
> 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.

28 TAC §134.203 sets out reimbursement guidelines for professional medical services, states in pertinent part, "(c) To determine the maximum allowable reimbursement (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 date of service, the requester billed CPT code 97550-FC X 8 units.

The MPPR Rate File that contains the payments for 2022 services is found at 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 = MAR.

- MPPR rates are published by carrier and locality.
- Disputed service was rendered in zip code 75043, locality 11, Dallas.
- The disputed date of service is December 13, 2022.
- The Medicare participating amount for CPT code 97750 in 2022 at this locality is $34.77 for the first unit, and $25.54 for 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 is $385.44.
- The respondent paid $0.00.
- Reimbursement of $385.44 is recommended.

The division finds that the requester has established that reimbursement is due.

4. At the time of filing this MFDR request, the requester was seeking reimbursement in the amount of $174.72, the amount originally billed to the IC, for CPT code 99213 rendered on January 5, 2023.

   The division has since been notified and provided documentation by the respondent that payment in the amount of $174.71 was processed on February 23, 2023 to reimburse the requester for the disputed office visit, CPT code 99213, rendered on January 5, 2023.

   The division finds that the requester is not entitled to additional reimbursement.

5. The requester seeks reimbursement in the amount of $15.00 for Work Status Report coded 99080-73 rendered on January 5, 2023.

   The disputed Work Status Report service will be reviewed in accordance with 28 TAC §129.5.

   28 TAC §129.5(i)(1) states "Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15. A doctor shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section."

   28 TAC §129.5 (d)(1) and (2) states "The doctor shall file the Work Status Report: (1) after the initial examination of the employee, regardless of the employee's work status; (2) when the employee experiences a change in work status or a substantial change in activity restrictions."

   Review of the DWC-73 report rendered on January 5, 2023, finds that the requester met the documentation requirements outlined in 28 TAC §129.5, therefore, reimbursement of $15.00 is recommended for this report.

   The division finds that the requester is entitled to reimbursement in the amount of $15.00, for Work Status Report 99080-73.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The division finds the requester is entitled to additional reimbursement for services, 97750-FC and 99080-73, in dispute.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to $400.44 reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requester $400.44 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		May 26 , 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.