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

General Information

Requestor Name
Nicholas Spruell, D.C.

Respondent Name
Arch Insurance Co.

MFDR Tracking Number
M4-23-1664-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
March 14, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
12/06/2022	97750	$214.06	$0.00

Requestor's Position

"... FCE's are billed in 15 minute increments and displayed as such on the units column of the HCFA. Each unit is billed accordingly based on Medical Fee Guideline conversion factors as established by DWC rule. The claim was billed per Medical Fee Guideline conversion factors as established in Rule 134.203 (c) (2) ... "

Amount in Dispute: $214.06

Respondent's Position

"... The provider billed $876.12. He acknowledges that the carrier had already paid him the amount of $662.06. The provider is seeking additional reimbursement of $214.06. We are attaching a copy of the carrier's CMS 1500, the carrier's EOR in response to it dated December 22, 2022, the provider's request for reconsideration and the carrier's EOR dated January 11, 2023. The carrier's initial EOR that recommended payment of $662.06 which is the amount that has been paid. No additional payment was recommended in the second EOR. We are attaching a copy of the calculations that led to the payment of $662.06. Carrier's position is that that amount represents the correct payment for the services in question. The provider is not entitled to any additional payment..."

Response Submitted by: Arch Indemnity Insurance Co.

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.

Denial Reasons

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

- 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules.
- 119 – Benefit maximum for this time period or occurrence has been reached.
- 193 – Original payment decision is being maintained.
- 1014 - The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 2005 – No additional reimbursement allowed after review of appeal / reconsideration.
- W3 – Bill is a reconsideration or appeal.

Issues

1. Is the Insurance Carrier's reimbursement reduction reason(s) supported?
2. Is the Requestor entitled to additional reimbursement for CPT code 97750-FC?

Findings

1. The insurance carrier reduced the disputed service, 97750-FC, with reduction code 163 (description indicated above).

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

   On the disputed date of service, the requestor billed CPT code 97550-FC X 14 units.

   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.

The division finds that the Insurance Carrier's reimbursement reduction reason is supported.

2. The requester is seeking additional reimbursement of $214.06 for 14 units of CPT code 97750-FC rendered on December 6, 2022.

   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."

   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. "

   28 TAC §134.203 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 requestor billed CPT code 97550-FC X 14 units.

   As described in Finding #1 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 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 December 6, 2022.
- The disputed service was rendered in zip code 75247, locality 11.
- The Medicare participating amount for CPT code 97750 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 $662.06
- The respondent paid $662.06
- No additional reimbursement is recommended.

The division 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.

The division 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 entitled to $0.00 reimbursement for the disputed service.

Authorized Signature

		April 13, 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.