



## Medical Fee Dispute Resolution Findings and Decision General Information

**Requestor Name**

Javier S. Hernandez, D.C.

**Respondent Name**

Standard Fire Insurance Co.

**MFDR Tracking Number**

M4-23-1677-01

**Carrier's Austin Representative**

Box Number 5

**DWC Date Received**

March 15, 2023

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
12/07/2022	97750	\$584.58	\$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). The DWC Division Ratio/conversation factors for the date of service billed are utilized for this claim."

**Amount in Dispute:** \$584.58

### Respondent's Position

"The Carrier has reviewed the documentation and determined the Provider is entitled to supplemental reimbursement for the disputed services, however, not in the amount requested by the Provider due to the application of the multiple procedure rule... Supplemental reimbursement for these services is being issued in the amount of \$354.80 in accordance with the Texas Workers' Compensation Act and adopted Rules of the Division of Workers' Compensation. With the supplemental reimbursement being issued, the Carrier contends the Provider is not entitled to additional reimbursement."

**Response Submitted by:** Standard Fire 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.

### Adjustment Reasons

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

- P12 – Workers' Compensation Jurisdictional Fee Schedule adjustment.
- 947 – Upheld, no additional allowance has been recommended.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 1001 - Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
- 2008 – Additional payment made on appeal/reconsideration.

### Issues

1. Did the requester receive a supplemental reimbursement after the medical fee dispute resolution (MFDR) was requested?
2. Is the Requestor entitled to additional reimbursement for CPT code 97750-FC?

### Findings

1. The requester is seeking additional reimbursement of \$584.58 for 16 units of CPT code 97750-FC rendered on December 7, 2022, per DWC060 MFDR request form submitted.

Review of submitted documentation finds that the health care provider was reimbursed \$370.30 on January 24, 2023. The requester's DWC060 MFDR request form was received by the division on March 15, 2023.

Per documentation made available to the division after receiving the requester's DWC060 request form, a supplemental reimbursement was issued to the health care provider in the amount of \$354.80 on April 5, 2023.

The division finds that as of the date of this review, the requester has been reimbursed a total amount of \$725.10 for 16 units of CPT code 97750-FC rendered on December 7, 2022.

2. The requester is seeking additional reimbursement for 16 units of CPT code 97750-FC rendered on December 7, 2022.

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

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 28 TAC §134.203 applies to the reimbursement of CPT code 97750, in which (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 documented and billed CPT code 97550-FC X 16 units.

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: [www.cms.gov/Medicare/Billing/TherapyServices](http://www.cms.gov/Medicare/Billing/TherapyServices).

To determine the MAR the following formula is used:

$$(DWC \text{ Conversion Factor} / Medicare \text{ Conversion Factor}) \times Medicare \text{ Payment} = MAR.$$

- MPPR rates are published by carrier and locality.
- The disputed date of service is December 7, 2022.
- The disputed service was rendered in zip code 79761, locality 99, rest of Texas.
- The Medicare participating amount for CPT code 97750 at this locality is \$33.16 for the first unit, and \$24.57 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 \$725.04.
- The respondent paid \$725.10.
- 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**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

June 30, 2023  
\_\_\_\_\_  
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](http://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](mailto: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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).