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

General Information

Requestor Name
Gulf Coast Functional Testing

Respondent Name
XL Insurance America Inc

MFDR Tracking Number
M4-23-2348-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
May 17, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 11, 2022	97750 FC GP	$750.0	$485.24
	Total	$750.00	$485.24

Requestor's Position

"The treating doctor recommended the services. We feel that our facility should be paid according to workers compensation fee schedule guidelines."

Amount in Dispute: $750.00

Respondent's Position

Response Submitted by: "...the bills in question were escalated and a review completed. Our bill audit company has determined that no further payment is due. Rationale: The charges were denied for no authorization."

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 §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.600 sets out the requirements of prior authorization,
3. 28 TAC §134.225 sets the reimbursement guidelines for FCEs.
4. 28 TAC §134.203 sets out the fee guidelines for professional services.

Denial Reasons

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

- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
- 197 – Payment denied/reduced for absence of precertification/authorization.

Issues

1. Is insurance carrier's denial based on lack of prior authorization supported?
2. What rule(s) are applicable to reimbursement?
3. Is xx entitled to additional reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $750 for CPT code 97750-FC rendered on October 11, 2022. The insurance carrier denied the disputed service based on lack of prior authorization. DWC Rule 134.600 (p)(9) states, (p) Non-emergency health care requiring preauthorization includes:

   (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay;

   (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;

   (3) spinal surgery;

   (4) all work hardening or work conditioning services;

(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:

(A) Level I code range for Physical Medicine and Rehabilitation, but limited to:

(i) Modalities, both supervised and constant attendance;

(ii) Therapeutic procedures, excluding work hardening and work conditioning;

(iii) Orthotics/Prosthetics Management;

(iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code; and

(B) Level II temporary code(s) for physical and occupational therapy services provided in a home setting;

(C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following:

(i) the date of injury; or

(ii) a surgical intervention previously preauthorized by the insurance carrier;

(6) any investigational or experimental service or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care;

(7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized return-to-work rehabilitation program;

(8) unless otherwise specified in this subsection, a repeat individual diagnostic study:

(A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline; or

(B) without a reimbursement rate established in the current Medical Fee Guideline;

(9) all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental);

(10) chronic pain management/interdisciplinary pain rehabilitation;

(11) drugs not included in the applicable division formulary;

(12) treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits);

(13) required treatment plans; and

(14) any treatment for an injury or diagnosis that is not accepted by the insurance carrier under Labor Code §408.0042 and §126.14 of this title (relating to Treating Doctor Examination to Define the Compensable Injury).

Review of the rule applicable to prior authorization does not support that the disputed service required prior authorization. The requestor's denial is not supported. The disputed service will be reviewed per applicable fee guideline.

2. The fee guideline for FCEs is found at 28 TAC §134.225.

DWC Rule 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. "

DWC Rule 28 TAC §134.203(c)(1) states in pertinent part, "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."

DWC Rule 28 Texas Administrative Code §134.203(c)(2) states "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. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

DWC Rule 28 TAC §134.203(b) 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.

On the disputed dates of service, the requestor billed CPT code 97550-FC (X10). The Medicare payment policy Multiple Procedure Payment Reductions applies to the disputed service.

Medicare Claims Processing Manual Chapter 5, 10.3.7-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).
>
> 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.

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

- MPPR rates are published by carrier and locality.
- Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 77076 which is in Houston, Texas; therefore, the Medicare locality is "18."
- The carrier code for Texas is 4412 and the locality code for Houston is 18.
- The Medicare participating amount for CPT code 97750 at this locality is $35.21 for the first unit, and $25.95 for subsequent units.

The DWC conversion factor for 2022 is 62.46.

The Medicare conversion factor for 2022 is 34.6062.

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

Using the above formula, the MAR is $63.55 for the first unit, and $46.85 x 9 for a total of $485.24. This amount is recommended for reimbursement.

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 the requester has established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that XL Insurance Co. must remit to Gulf Coast Functional Testing $485.24 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 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.