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

General Information

Requestor Name
Robert J. Coolbaugh, D.C.

Respondent Name
Federal Insurance Co.

MFDR Tracking Number
M4-24-1066-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
January 15, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 20, 2023	97750-FC	$615.00	$576.17
September 20, 2023	99080-73	Left blank	$0.00
	Total	$615.00	$576.17

Requestor's Position

The submitted documentation does not include a position statement from the requestor. Accordingly, this decision is based on the information available at the time of adjudication.
Amount in Dispute: $615.00

Respondent's Position

"...it was determined the charges in dispute were appropriately denied with claim adjustment reason code 50 (Services not Deemed 'Medically Necessary' by payer) based on retrospective utilization review... A reconsideration was received by the carrier on 11/21/2023. As required by rule, a request for appeal of a previous retrospective review was submitted and peer reviewed by... who also confirmed the previous adverse determination. As such, the original denial was maintained."
Response Submitted by: CorVel

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 (TAC) Code §133.307 sets out the procedures for resolving medical fee disputes (MFDR).
2. 28 TAC §134.240 sets out guidelines of medical bill processing and auditing by insurance carriers.
3. 28 TAC, Chapter 19 sets out the requirements for utilization review.
4. 28 TAC §137.100 sets out disability treatment guidelines.
5. 28 TAC §134.225 sets the reimbursement guidelines for FCEs.

Denial Reasons

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

- 50 – Service not deemed 'Medically Necessary' by payer.
- 16 – Svc lacks info needed or has billing error(s).
- 252 – Attachment required to adjudicate claim/service.
- Remarks: *N706 – Missing documentation; *FC – appears to be interim FCE; *73 – DWC-73 Required.

Issues

1. Is the insurance carrier's denial of payment based on lack of medical necessity supported?
2. Is the requestor entitled to reimbursement for CPT code 97750-FC?
3. Is the requestor entitled to reimbursement for CPT code 99080-73?

Findings

1. The insurance carrier denied reimbursement for the services in dispute in part based on lack of medical necessity.

   DWC Rule 28 TAC §137.100 (e) states, "An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017."

Retrospective utilization review is defined in 28 TAC §19.2003 (b)(31) as, "A form of utilization review for health care services that have been provided to an injured employee. Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted."

28 TAC §133.307 (d)(2)(I) which sets out the procedures for medical fee dispute resolutions, states in pertinent part, "Response. On receipt of the request, the respondent must provide any missing information not provided by the requestor and known to the respondent. The respondent must also provide the following information and records: … (I) If the medical fee dispute involves medical necessity issues, the insurance carrier must attach documentation that supports an adverse determination in accordance with §19.2005 of this title (concerning General Standards of Utilization Review)."

The respondent in its position statement asserts that the lack of medical necessity denial is based on a utilization review. However, no documentation was included with the DWC060 response to support an adverse determination pursuant to 28 TAC §19.2003.

DWC finds that the insurance carrier's denial reason, based on lack of medical necessity, is not supported.

2. The requestor is seeking reimbursement for 12 units of CPT code 97750-FC rendered on September 20, 2023. CPT Code 97750-FC is defined as a functional capacity evaluation.

The following Texas Administrative Code Rules apply to the reimbursement of 97750-FC: 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."

On the disputed date of service, the requestor billed CPT code 97750-FC X 12 units.

Medicare Claims Processing Manual Chapter 5, 10.7-effective June 6, 2016, titled Multiple Procedure Payment Reductions (MPPR) 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.

DWC finds that the MPPR discounting rule applies to the disputed service.

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. "

A review of the submitted documentation finds that on the disputed date of service the requestor documented and billed for three hours (12 units) of a functional capacity evaluation in accordance with 28 TAC §134.225. DWC finds that the requestor is entitled to reimbursement.

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..."

As described above, the MPPR discounting rule applies to the disputed service. The MPPR Rate File that contains the payments for 2023 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 79412, locality 99, Rest of Texas.
- The disputed date of service is September 20, 2023.
- The Medicare participating amount for CPT code 97750 in 2023 at this locality is $33.21 for the first unit, and $24.36 for each subsequent unit.
- The 2023 DWC Conversion Factor is 64.83
- The 2023 Medicare Conversion Factor is 33.8872

- The MAR amount for the first unit is $63.53 for the first unit and $46.60 for each subsequent unit.
- Using the above formula, DWC finds the MAR is $576.17.
- The insurance carrier paid $0.00 for the disputed service.
- Reimbursement in the amount of $576.17 is recommended.

DWC finds that reimbursement in the amount of $576.17 is due for the disputed CPT code 97750-FC x 12units rendered on September 20, 2023.

3. The requestor is seeking reimbursement for CPT code 99080-73, which represents a DWC73 Work Status Report.

   28 TAC §129.5(i)(1) which applies to the billing and reimbursement of Work Status Reports, 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."

   A review of the submitted documents finds no evidence that a DWC73 Work Status Report was completed on September 20, 2023. Therefore, DWC finds that the requestor is not entitled to reimbursement for CPT 99080-73 for the disputed date of service.

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 requestor has established that reimbursement in the amount of $576.17 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that Federal Insurance Co. must remit to Robert J. Coolbaugh, D.C. $576.17 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		February 28, 2024
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.