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

General Information

Requestor Name
Functional Recovery Associates

Respondent Name
Travis County

MFDR Tracking Number
M4-24-2929-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 27, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 7, 2023	97750-GP-FC x 12 units	$931.92	$599.82
	Total	$931.92	$599.82

Requesters' Position

"Please reconsider the enclosed explanation of benefits for the following current procedural terminology code 97750 physical performance test or measurement of musculoskeletal function and the FC modifier is for functional capacity... Three hours for the discharge test - $77 .66 x 12 units = $931.92."

Amount in Dispute: $931.92

Respondents' Position

"Per the Explanation of Benefits (EOB) dated November 20, 2023, the bill was denied because the procedure code or type of bill was inconsistent with the place of service. The place of service was listed as 62, which generally refers to a comprehensive inpatient rehabilitation facility. The billed code was 97750, which is used for physical performance tests or evaluations, typically performed in outpatient settings. The modifiers used were GP (indicating services provided under a physical therapy plan) and FC (indicating an applicable fee schedule adjustment). Since this procedure code and its modifiers were billed for 12 days in a setting inconsistent with place of service code

62, the discrepancy resulted in denial. The Requestor attached a "Request for Reconsideration," but Respondent has no record of receipt or indication explaining the discrepancy."

Response Submitted by: Flahive, Ogden & Latson

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §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) §133.305 sets out the procedures for resolving medical disputes.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 TAC §134.203 sets out the fee guideline for professional medical services.
4. 28 TAC §134.225 sets the reimbursement guidelines for FCEs.

Denial Reasons

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

- 45 – Charge exceeds fee schedule/maximum allowable or contracted legislated fee arrangement.

Issues

1. Did the insurance carrier raise new issues after the submission of DWC060?
2. Is the insurance carrier's denial supported?
3. Do the CMS Multiple Procedure Payment Reduction (MPPR) policies apply?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier states in pertinent part, "Per the Explanation of Benefits (EOB) dated November 20, 2023, the bill was denied because the procedure code or type of bill was inconsistent with the place of service. The place of service was listed as 62, which generally refers to a comprehensive inpatient rehabilitation facility…"

   A review of the CMS1500 finds the requestor billed the following:

   - The disputed services were rendered at P.R.I.D.E on November 07, 2023.
   - The requestor billed 12 units of CPT code 97750-GP-FC, in the amount of $931.92.
   - Place of service code 62 was found in Box 24B of CMS 1500.

- The description of place of service code 62 indicates that the services were rendered in a Comprehensive Outpatient Rehabilitation Facility.
- NPI Profile box 32 (a) contains NPI No. 1871607671
- NPI No. is registered as a "Clinic/Center - Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF) in Dallas, TX."

A review of the medical documentation finds that the insurance carriers' reason for denial raised after the submission of the DWC060 is not supported. The disputed service is therefore reviewed pursuant to the applicable rules and guidelines.

2. This dispute pertains to the non-payment of a functional capacity evaluation, billed under CPT code 97750-FC, rendered on November 07, 2023. The requester seeks reimbursement in the amount of $931.92. The insurance carrier denied the disputed service with denial reduction code "45" (description provided above).

   The insurance carrier allowed $0.00 with reduction code 45. A review of the documentation presented with the DWC060 dispute finds that the insurance carrier submitted no information to support that a contract exists between the parties involved in this dispute. In addition, the requestor was reimbursed $0.00 for the disputed services, no contract amount was taken during the medical bill review process. DWC finds that this denial reason is not supported. As a result, the disputed service is reviewed pursuant to the applicable rules and guidelines.

3. The DWC specific CPT code 97750-FC is described as, "Functional Capacity Evaluation."

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

   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."

   28 TAC §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   On the disputed date of service, the requester billed the CPT code 97750-FC (x 12 units). The multiple procedure rule discounting 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.
>
> 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 the 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 MPPR Rate File that contains the payments for 2023 services is found at https://www.cms.gov/Medicare/Billing/TherapyServices/index.html. The MPPR rates are published by carrier and locality.

4. 28 TAC §134.203(c)(1) states, "…To determine to MAR for professional services, system participants shall apply the Medicare payment policies with minimal modification…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 $53.68…"

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

   - The disputed service is dated November 7, 2023
   - The 2023 DWC Conversion Factor is 64.83
   - The 2023 Medicare Conversion Factor is 33.8872

   - The CMS-1500 finds zip code 78746 in box 32, the Medicare locality is therefore 4412-31, rest of Texas.
   - The Medicare Participating amount for CPT code 97750 at this locality is $35.12 for the first unit, and $25.31 for subsequent units.

- Using the above formula, the DWC finds the MAR is $67.19 for the first unit, and $48.42 for the subsequent 11 units, $532.63, for a total MAR $599.82.
- The requestor seeks $931.92.
- The respondent paid $0.00.
- Reimbursement of $599.82 is recommended.

The DWC finds that the requestor is entitled to reimbursement for the disputed services. As a result, $599.82 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 DWC finds the requestor has established that reimbursement 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 the respondent must remit to the requestor $599.82 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 28, 2025 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, 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.