TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Nicholas Allen Spruell, D.C.

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-25-0815-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
December 9, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 28, 2024	97750 FC x 12	$414.31	$196.46

Requestor's Position

"The carrier denied this claim incorrectly. This is a Designated Doctor referred testing and not subject to benefit maximum for the tie [*time*] period as Designated Doctor and/or DWC referred testing does not count towards the three maximum FCE's allowed. Additionally, the carrier inappropriately applied the multiple procedure rules for reasons noted below and we have provided proof of such. "

Amount in Dispute: $414.31

Respondents' Position

"Please see the EOBs included in with Requestor's DWC-60. The Carrier has paid a total of $423.61 for the FCE per the fee guidelines. In conclusion, Requestor is not owed any additional reimbursement for the FCE as the proper amount was paid per the fee guidelines."

Response Submitted by: Downs & Stanford, P.C.

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 the payment for the disputed service with the following claim adjustment codes:

- 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules.
- 600 – Allowance based on maximum number of units allowed according to the fee schedule and/or service code description or regulations.
- 119 – Benefit maximum for this time period or occurrence has been reached.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- N600 – Adjusted based on the applicable fee schedule for the region in which the service was rendered.
- OA – Other adjustment.

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 requestor billed 12 units of CPT code 97750-FC rendered on March 28, 2024. The insurance carrier issued a payment in the amount of $423.61 and reduced the remaining charges with denial reduction reason code 163 and 119 (description indicated above). The requestor seeks an additional payment in the amount of $414.31.

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

A review of submitted medical documentation finds that the insurance carriers did not submit any evidence to support that the benefit maximum for this service had been reached. As a result, the denial reason 119 is not supported.

A review of the submitted medical documentation finds that the healthcare provider documented and billed a 3- hour functional capacity evaluation. The insurance carrier applied the multiple procedure payment reduction and issued a payment of $423.61. The division finds that the multiple procedure payment reduction applies to the disputed service, as a result, the Insurance Carrier's reimbursement reduction reason 163 is supported.

2. The insurance carrier issued a payment in the amount of $423.61 for the disputed service. The requestor is seeking additional reimbursement in the amount of $411.39 for 12 units of CPT code 97750-FC rendered on March 28, 2024.

   The following rule applies 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."

   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 97750-FC x 12 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 2024 services are found at https://www.cms.gov/medicare/coding-billing/therapy-services.

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 service was rendered in zip code 75247, locality 11, Dallas; carrier 4412.
- The disputed date of service is March 28, 2024.
- The Medicare participating amount for CPT code 97750 in 2024B at this locality is $33.79 for the first unit, and $24.60 for the subsequent 11 units.
- The 2024 DWC Conversion Factor is 67.81
- The 2024 Medicare Conversion Factor is 33.2875
- Using the above formula, the MAR for the first unit is $68.83 and $551.24 for the subsequent 11 units, for a total MAR of $620.07
- The respondent paid $423.61.
- Additional reimbursement of $196.46 is recommended.

DWC finds 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.

DWC finds the requestor has established that additional reimbursement of $196.46 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement. It is ordered that the respondent must remit to the requestor, $196.46 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		February 21, 2025
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.