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
PRIDE

Respondent Name
Travis County

MFDR Tracking Number
M4-25-0970-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
January 6, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 21, 2024	97750-GO-FC x 9 units	$1,000.00	$478.76
May 28, 2024	97162-GP	$201.00	$201.00
June 17, 2024	97799-CP-CA-GP-GO x 6 units	$625.00	$625.00
June 20, 2024	97799-CP-CA-GP-GO x 6 units	$625.00	$625.00
	Total	$2,451.00	$1,929.76

Requesters' Position

"The claim was reduced to $0 per hour with the rational code of fair and reasonable. The current procedural terminology code 97799-CP-CA is an unlisted physical medicine/rehabilitation service and/or procedure. The modifier CP is for chronic pain management and the CA modifier is for CARF accredited programs. The commission agrees with the commenter's support of the reimbursement rate for interdisciplinary pain management programs in the amount of$125.00 per hour is the maximum allowed reimbursement for this procedure code."

Amount in Dispute: $2,451.00

Respondents' Position

"We are attaching a copy of the provider's CMS 1500s and the carrier's EOBs. The carrier's position remains the same as outlined in its EOBs. The provider is not entitled to any additional payment."

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 Functional Capacity Evaluations (FCEs).

Denial Reasons

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

CPT code 97750-GO-FC

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

CPT code 97162

- 5 – The procedure code/type of bill is inconsistent with the place of service.
- Note: coding edit.

CPT code 97799-CP-CA

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- N640 – Exceeds number/frequency approved/allowed within time period.
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.
- Note: NCCI-MUE

Issues

1. Is the insurance carrier's denial reason supported for CPT code 97750-FC?
2. Is the insurance carrier's denial reason supported for CPT code 97162-GP?
3. Is the insurance carrier's denial reason supported for CPT code 97799-CP-CA?
4. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for a functional capacity evaluation provided on May 21, 2024. The insurance carrier denied the disputed charge with denial reduction code "45-Charge exceeds fee schedule/maximum allowable or contracted legislated fee arrangement."

   The insurance carrier allowed $0.00 with reduction code 45. A review of the documentation presented with the DWC060, Medical Fee Dispute Resolution request, finds that the insurance carrier submitted no information to support that a contract exists between the parties involved in this dispute. In addition, no evidence was submitted to support that the functional capacity evaluation exceeded the fee schedule maximum/allowable.

   Due to the lack of evidence, the division concludes that the denial reason code "45", is not supported. For this reason, the requestor is entitled to reimbursement pursuant to 28 TAC §134.225.

   The 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 9 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 2024 services is found at https://www.cms.gov/Medicare/Billing/TherapyServices/index.html. The MPPR rates are published by carrier and locality.

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).

- Service date May 21, 2024
- The 2024 DWC Conversion Factor is 67.81
- The 2024B Medicare Conversion Factor is 33.2875
- The services were provided in zip code 78746.
- The Medicare locality is 4412 31, Austin.

- The Medicare Participating amount for CPT code 97750 at this locality is $34.78 for the first unit, and $25.03 for subsequent 8 units.
- Using the above formula, the DWC finds the MAR is $70.85 for the first unit, and $50.99 for the subsequent 8 units, $407.91, for a MAR amount $478.76.
- The requestor seeks $1,000.00.
- The respondent paid $0.00.
- Reimbursement of $478.76 is recommended.

2. The requester seeks reimbursement for a physical therapy evaluation billed under CPT code 97162 and rendered on May 28, 2024

   The insurance carrier denied the disputed service with denial reduction "5 – The procedure code/type of bill is inconsistent with the place of service" and "coding edit."

   A review of box 24B of the CMS-1500 finds that the requestor billed with place of service code "62", this code is used to identify that the service was provided in a Comprehensive Outpatient Rehabilitation Facility.

   The NPI profile box 32 (a) contains NPI No. 1871607671. This NPI No. is registered as a "Clinic/Center - Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF) in Dallas, TX."

   The division finds that the insurance carriers' reason for denial is not supported. The disputed service is therefore reviewed pursuant to the applicable rules and guidelines.

   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).

   - Service date May 28, 2024
   - The 2024 DWC Conversion Factor is 67.81
   - The 2024B Medicare Conversion Factor is 33.2875
   - The services were provided in zip code 78746.
   - The Medicare locality is 4412 31, Austin.

   - The Medicare Participating amount for CPT code 97162 at this locality is $102.27.
   - Using the above formula, the DWC finds the MAR is $208.33.
   - The requestor seeks $201.00.
   - The respondent paid $0.00.
   - Reimbursement of $201.00 is recommended.

3. The requester seeks reimbursement for CARF accredited chronic pain management services, billed under CPT code 97799-CP-CA and rendered on June 17, 2024, and June 20, 2024.

   The insurance carrier denied the disputed service with the following denial reduction codes:

   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - N640 – Exceeds number/frequency approved/allowed within time period.
   - P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.
   - Note: NCCI-MUE

   The requestor submitted a copy of a preauthorization, reference number 177177 issued by IMO, dated June 5, 2024. The authorization approved 80 hours of CPT 97799, for dates of service June 5, 2024, to August 31, 2024. A review of the CMS 1500, box 23 finds that the requestor referenced preauthorization number 177177.

   The division finds that the requestor provided the disputed services within the authorized timeframe. The insurance carrier submitted insufficient evidence to verify whether the requestor exceeded the frequency, time period, and the number of sessions authorized by the insurance carrier. For this reason, reimbursement is recommended for the CARF accredited chronic pain management services, provided on June 17, 2024, and June 20, 2024.

   The applicable fee guideline for determining reimbursement for chronic pain management services is found at 28 TAC §134.230.

   28 TAC §134.230 states, "The following shall be applied to Return-to-Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a division, Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or insurance carrier….

   (1) Accreditation by the CARF is recommended but not required.

   (A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the maximum allowable reimbursement (MAR)…

(5) The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs.

(A) Program shall be billed and reimbursed using CPT code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the unit's column on the bill. CARF accredited programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15-minute increments. A single 15-minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

The requestor billed 6 hours of chronic pain management on each disputed date of service for a total of 12 hours.

The requestor billed $960.00 for 6 hours of chronic pain management on each of the disputed dates of service, for a total billed amount of $1,920.00. The MAR amount is calculated at $125/hour for 12 hours for a total amount of $1,500.00. The insurance carrier reimbursed the requestor $250.00, prior to the Medical Fee Dispute Resolution submission. The division finds that the requester is therefore entitled to an additional payment of $1,250.00. This amount is recommended.

4. The DWC finds that the requestor is entitled to reimbursement in the amount of $1,929.76.

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 $1,929.76 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		April 28, 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, 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.