TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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-MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
DR. SIMON J. FORSTER

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number
M4-19-1687-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
NOVEMBER 21, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are submitting a request for reconsideration in response to a denial of the $209.96 for the Designated Doctor Referred Exam performed on 06/26/2018…**Any additional testing is performed separately to the exams, and not as a component of the exams**."

Amount in Dispute: $209.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Supplemental response will be provided once the bill auditing company has finalized their review."

Response Submitted By: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 26, 2018	CPT Code 97750-GP (X4) Physical Performance Testing	$209.96	$197.74

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, sets the fee guideline for professional services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 00663-Reimbursement has been calculated according to state fee schedule guidelines.
   - 00137, 97-The benefit for this service is i included in the payment/allowance for another service/procedure that has already been adjudicated.
   - W3-Request for reconsideration.
   - 193-Original payment decision is being maintained. This claim was processed properly the first time.

Issues

1. What is the applicable fee guideline?
2. Is the respondent's denial of payment supported?
3. Is the requestor due reimbursement?

Findings

1. The applicable fee guideline for 97750-GP is found at 28 Texas Administrative Code §134.203.
2. According to the submitted explanation of benefits the respondent denied reimbursement for the testing based upon "The benefit for this service is i included in the payment/allowance for another service/procedure that has already been adjudicated."

   On the disputed date of service, the requestor billed for CPT codes 97750-GP, 99456-W5-WP, 99456-SP, 99456-W5-MI and 99456-RE-W6. Only code 97750-GP is in dispute.

   The requestor wrote, "We are submitting a request for reconsideration in response to a denial of the $209.96 for the Designated Doctor Referred Exam performed on 06/26/2018…**Any additional testing is performed separately to the exams, and not as a component of the exams**."

   To determine if the respondent's denial of payment is supported, the division refers to the following rules:

   - 28 Texas Administrative Code §134.250(5) states, "If the examination for the determination of MMI and/or the assignment of IR requires testing that is not outlined in the AMA Guides, the appropriate CPT code(s) shall be billed and reimbursed in addition to the fees outlined in paragraphs (3) and (4) of this section."

   - 28 Texas Administrative Code §134.235 states, "The following shall apply to return to work (RTW)/evaluation of medical care (EMC) examinations. When conducting a division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT code 99456 with modifier "RE." In either instance of whether maximum medical improvement/ impairment rating (MMI/IR) is performed or not, the reimbursement shall be $500 in accordance with §134.240 of this title and shall include division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee."

   - 28 Texas Administrative Code §127.10(c) states, "The designated doctor shall perform additional testing when necessary to resolve the issue in question. The designated doctor shall also refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question and the designated doctor is not qualified to fully resolve the issue in question. Any additional testing or referral required for the evaluation is not subject to preauthorization requirements nor shall those services be denied retrospectively based on medical necessity, extent of injury, or compensability in accordance with the Labor Code §408.027 and §413.014, Insurance Code Chapter 1305, or Chapters 10, 19, 133, or 134 of this title (relating to Workers' Compensation Health Care Networks, Agents' Licensing, General Medical Provisions, and Benefits--Guidelines for Medical Services, Charges, and Payments, respectively) but is subject to the requirements of §180.24 of this title (relating to Financial Disclosure). Any additional testing or referral examination and the designated doctor's report must be completed within 15 working days of the designated doctor's physical examination of the injured employee unless the designated doctor receives division approval for additional time before the expiration of the 15 working days. If the injured employee fails or refuses to attend the designated doctor's requested additional testing or referral examination within 15 working days or within the additional time approved by the division, the designated doctor shall complete the doctor's report based on the designated doctor's examination of the injured employee, the medical records received, and other information available to the doctor and indicate the injured employee's failure or refusal to attend the testing or referral examination in the report."

   The division finds per 28 Texas Administrative Code §134.235 and §127.10(c), allows for reimbursement for examination and any additional testing; therefore, the respondent's denial of payment is not supported.

3. 28 Texas Administrative Code §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.

The American Medical Association (AMA) Current Procedural Terminology (CPT) defines 97750 as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes." CPT code 97750 requires direct one-on-one patient contact.

28 Texas Administrative Code §134.203(c)(1) states:

> 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."

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.

CMS published Medical Learning Network (MLN) Matters, effective January 1, 2011 which states in part "Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The Centers for Medicare & Medicaid Services (CMS) is applying a MPPR to the practice expense payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures, furnished to the same patient on the same day, full payment is made for work and malpractice and 80 percent payment for the PE for services furnished in office settings and other non-institutional settings and at 75 percent payment for the PE services furnished in institutional settings." The multiple procedure rule discounting applies to the disputed service.

The Division conversion factor for 2018 is $58.31.

The Medicare conversion factor for 2018 is 35.9996.

Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 78758 which is located in Austin, Texas; therefore, the Medicare locality is "Austin, Texas."

The Medicare participating amount for CPT code 97750 is $38.79.

Using the above formula the MAR is $38.79/unit. The requestor billed for 4 units; therefore, $38.79 X 4 X MPPR = $197.74. The respondent paid $0.00. The requestor is due the difference between MAR and amount paid of $197.74.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $197.74.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $197.74 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		1/30/2019
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

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Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.