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
DALLAS TESTING, INC

Respondent Name
STANDARD FIRE INSURANCE CO

MFDR Tracking Number
M4-19-4665-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
JUNE 25, 2019

REQUESTOR'S POSITION SUMMARY

"The above date of service has been returned due to reason: 'The procedure c ode is inconsistent with the modifier used or a required modifier is missing.' **This is incorrect**. The correct modifier for a **PHYSICAL PERFORMANCE EVALUATION** is **GP**. **The appropriate modifier was used**."

Amount in Dispute: $464.48

RESPONDENT'S POSITION SUMMARY

No response was received.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 26, 2019	CPT Code 97750-GP (X8) Physical Performance Testing	$464.48	$358.21

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, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 set out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following claim adjustment reason codes:
   - 4-The procedure code is inconsistent with the modifier used or a required modifier is missing.

Issues

1. Did the insurance carrier respond to the medical fee dispute?

2. Is the requestor due reimbursement for CPT code 97750-GP rendered on March 26, 2019?

Findings

1. The Austin carrier representative for Standard Fire Insurance Co is Travelers Co. Inc. Travelers Co. Inc. acknowledged receipt of the copy of this medical fee dispute on July 3, 2019. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information

   As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

2. The requestor billed CPT code 97750-GP.

3. The applicable fee guideline for 97750-GP is found at 28 Texas Administrative Code §134.203.

4. According to the submitted explanation of benefits the respondent denied reimbursement for the testing based upon "The procedure code is inconsistent with the modifier used or a required modifier is missing."

5. 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."

6. 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." The requestor appended modifier "GP-Services delivered under an outpatient physical therapy plan of care."

7. Medicare Claims Processing Manual, 100-04, Chapter 5, titled *Part B Outpatient Rehabilitation,* Section 20.2-Reporting of Service Units with HCPCS, effective January 1, 2017, describes the Medicare requirements for counting minutes for timed codes including 97750.

8. The division finds the respondent did not support the denial of payment for code 97750-PG. The documentation supports the requestor performed a "PPE Summary Report" for two hours; therefore, reimbursement is recommended.

9. 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."

   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 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.

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

The Division conversion factor for 2019 is $59.15.

The Medicare conversion factor for 2019 is 36.0391.

Review of Box 32 on the CMS-1500 finds that the services were rendered at Medicare locality “Fort Worth, Texas.”

The Medicare participating amount for CPT code 97750 is $35.35.

Using the above formula, the MAR is $58.05 per unit. The requestor billed for 8 units; therefore, $58.05 X 8 + multiple procedure discounting = $358.21. The respondent paid $0.00. The requestor is due the difference between MAR and amount paid of $358.21.

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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 $358.21.

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 $358.21 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

______________________	______________________	8/29/2019
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.