



# 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**

HARTFORD CASUALTY INSURANCE CO

**MFDR Tracking Number**

M4-21-0016-01

**Carrier's Austin Representative**

Box Number 47

**MFDR Date Received**

SEPTEMBER 4, 2020

#### REQUESTOR'S POSITION SUMMARY

"The fee schedule allows for \$472.64 to be charged for a PHYSICAL PERFORMANCE EVALUATION that lasts 2 HOURS."

**Amount in Dispute:** \$472.64

#### RESPONDENT'S POSITION SUMMARY

"The provider submitted billing for a physical performance evaluation (PPE). This was denied for authorization in accordance with 28 TAC Rule §134.600 as the provider has billed a total of 6 PPE's."

**Response Submitted By:** The Hartford

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 19, 2019	CPT Code 97750-GP (X8)	\$472.64	\$0.00

#### FINDINGS AND DECISION

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

##### **Background**

- 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2012 sets out the procedures for resolving medical fee disputes.
- 28 TAC §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
- 28 TAC §134.600, effective November 1, 2018, requires preauthorization for specific treatments and services.
- The insurance carrier reduced payment for the disputed services with the following claim

adjustment codes:

- 18-Exact duplicate claim/service.
- 247-A payment or denial has already been recommended for this service.
- 309-The charge for this procedure exceeds the fee schedule allowance.
- P12-Workers' compensation jurisdictional fee schedule adjustment.
- AUTH-Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. Pre-authorization was not obtained and treatment was rendered without the approval of treating doctor. If you require additional information regarding this bill decision, contact the claim handler.

### **Issues**

Is the requestor entitled to reimbursement for physical performance evaluation rendered on September 19, 2019?

### **Findings**

1. The requestor is seeking reimbursement in the amount of \$472.64 for physical performance evaluation, CPT code 97750, rendered on September 19, 2019.
2. The respondent denied reimbursement for the disputed physical therapy services based upon a lack of preauthorization.
3. To determine if the disputed services are eligible for reimbursement the DWC refers to the following statute:
  - 28 TAC §134.600 (p) states,  
Non-emergency health care requiring preauthorization includes: (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to: (i) Modalities, both supervised and constant attendance; (ii) Therapeutic procedures, excluding work hardening and work conditioning.
  - 28 TAC §134.600 (f) states,  
The requestor or injured employee shall request and obtain preauthorization from the insurance carrier prior to providing or receiving health care listed in subsection (p) of this section. Concurrent utilization review shall be requested prior to the conclusion of the specific number of treatments or period of time preauthorized and approval must be obtained prior to extending the health care listed in subsection (q) of this section. The request for preauthorization or concurrent utilization review shall be sent to the insurance carrier by telephone, facsimile, or electronic transmission and, include the:
    - (2) specific health care listed in subsection (p) or (q) of this section;
    - (3) number of specific health care treatments and the specific period of time requested to complete the treatments.
4. The requestor billed CPT code 97750-GP. CPT code 97750 is described as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes". The requestor appended the "GP" modifier to 97750. The "GP" modifier is described as "Services delivered under an outpatient physical therapy plan of care." The DWC finds physical therapy services require preauthorization per rule 134.600. The requestor did not submit any documentation to support preauthorization was obtained for CPT code 97750-GP; therefore, the respondent's denial of payment is supported.

**Conclusion**

For the reasons stated above, the DWC finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

**ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the DWC has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

**Authorized Signature**

		10/05/2020
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 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **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.**