



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

DALLAS TESTING, INC

Respondent Name

OLD REPUBLIC INSURANCE CO

MFDR Tracking Number

M4-21-0864-01

Carrier's Austin Representative

Box Number 44

MFDR Date Received

JANUARY 25, 2021

REQUESTOR'S POSITION SUMMARY

"The above date of service was not paid in full due to the following reasons(s): 'The procedure code 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."

Amount in Dispute: \$422.94

RESPONDENT'S POSITION SUMMARY

"The bill in question was denied as the Requestor did not bill with the correct modifier, 'FC'."

Response Submitted By: White Espey, PLLC

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: October 8, 2020, CPT Code 97750-GP (X7) Physical Performance Evaluation (PPE), \$422.94, \$326.97

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

- 1. 28 Texas Administrative Code §133.307 (TAC), effective May 31, 2012 sets out the procedures for resolving a medical fee dispute.
2. 28 TAC §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment code:
 - 4-The procedure code is inconsistent with the modifier used or a required modifier is missing.
 - N572-This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted.
 - 10-The billed service requires the use of a modifier.
 - 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
 - 193-Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly.
 - W3-Additional payment made on appeal/reconsideration.

Issues

Is the requestor entitled to reimbursement for CPT code 97750-GP (X7) rendered on October 8, 2020?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of \$422.94 for CPT code 97750-GP (X7) rendered on October 8, 2020.
2. According to the explanation of benefits, the carrier denied payment for the disputed test based upon "The procedure code is inconsistent with the modifier used or a required modifier is missing."
3. The fee guidelines for disputed services is found at 28 TAC §134.203.

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."

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 both codes. The "GP" modifier is described as "Services delivered under an outpatient physical therapy plan of care."

The requestor billed for the PPE in accordance with the fee guideline; therefore, the respondent's denial of payment is not supported.

4. 28 TAC §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."

On the disputed dates of service, the requestor billed CPT code 97550-GP (X7). 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 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 2020 services is found at <https://www.cms.gov/Medicare/Billing/TherapyServices/index.html>.

- MPPR rates are published by carrier and locality.
- Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 75006 which is located in Carrollton, Texas; therefore, the Medicare locality is “Dallas, Texas.”
- The carrier code for Texas is 4412 and the locality code for Dallas is 11.
- The Medicare participating amount for CPT code 97750 at this locality is \$36.15 for the first unit, and \$26.58 for subsequent units.

The DWC conversion factor for 2020 is 60.32.

The Medicare conversion factor for 2020 is 36.0896.

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

Using the above formula, the MAR is \$60.42 for the first unit, and \$44.43 for the subsequent units, for a total of \$326.97. The respondent initially paid \$0.00. The difference between MAR and amount paid is \$326.97; this amount is recommended for reimbursement.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$326.97.

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 DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of \$326.97 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		03/05/2021
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.