TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Dr. Michael Smith

Respondent Name
American Financial Alliance Insurance Co.

MFDR Tracking Number
M4-22-0784-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
December 29, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 17, 2021	CPT Code 97750-GP (X8) Physical Performance Evaluation (PPE)	$201.26	$0.00
	Total	$201.26	$0.00

Requestor's Position

"The fee schedule allows for $482.16 to be reimbursed for code 97750(GP)."

February 17, 2022: "Yes, please proceed. They only paid an additional 96.61."

Amount in Dispute: $201.26

Respondent's Position

"After further review it was determined that a PPO reduction was applied to the bill in the amount of $96.61. We have confirmed with the PPO Network that his provider is not in-network and therefore should be reimbursed the amount of $96.61.

"Response Submitted by: Medata

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §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) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.

Denial Reasons

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

- P12-The charge for the procedure exceeds the amount indicated in the fee schedule.
- 45-A PPO reduction was made for this bill and/or the bill was repriced according to a negotiated contract.
- W3-No additional reimbursement allowed after review of appeal/reconsideration.
- P12-Denial after reconsideration
- P12-Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Is American Financial Alliance Insurance Company's denial based on a negotiated contract supported?
2. Is Dr. Michael Smith entitled to additional reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $201.26 for CPT code 97750-GP (X8) rendered on June 17, 2021.

   The respondent reduced payment for CPT code 97750-GP based upon "45-A PPO reduction was made for this bill and/or the bill was repriced according to a negotiated contract."

   Upon receipt in MFDR, the respondent reconsidered payment and stated "After further review it was determined that a PPO reduction was applied to the bill in the amount of $96.61. We have confirmed with the PPO Network that his provider is not in-network and therefore should be reimbursed the amount of $96.61."

   The requestor confirmed payment of $96.61 was received.

2. 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." Based upon the code and modifier description CPT code 97750-GP is an outpatient physical therapy service.

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-FC (X8). 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 2021 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 75042 which is located in Garland, 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 $35.06 for the first unit, and $25.75 for subsequent units.
- The DWC conversion factor for 2021 is 61.17
- The Medicare conversion factor for 2021 is 34.9931.

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 $61.46 for the first unit, and $45.14 for the subsequent units, for a total of $377.45. The respondent initially paid $280.90 and subsequent payment of $96.61, for a total $377. 51. As a result, additional reimbursement is not recommended.

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.

DWC finds the requester has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	03/09/2022 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, please 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.