TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
PEAK INTEGRATED HEALTHCARE

Respondent Name
AIU INSURANCE COMPANY

MFDR Tracking Number
M4-22-1123-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
February 10, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 27, 2021	CPT Code 97750-GP (X 8) Physical Performance Evaluation (PPE)	$482.16	$0.00
	Total	$482.16	$0.00

Requestor's Position

"DWC rule 134.204(g) A maximum of 3 PPE'S For each compensable injury shall be billed and reimbursed. All necessary and supporting documentation is included with this reconsideration to properly justify/support the administered treatment still needing to be paid. Therefore, this claim should be PAID IN FULL to prevent IRO (independent Review Organization) and MFDR (Medical fee Dispute Resolution)."

Amount in Dispute: $482.16

Respondent's Supplemental Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bill in question for manual review to determine if additional monies are owed."

Response Submitted by: Gallagher Bassett

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 §134.225 sets the reimbursement guidelines for FCEs.
3. 28 TAC §134.600 requires preauthorization for specific treatments and services.
4. 28 TAC §134.203 sets out the fee guidelines for professional services.
5. 28 TAC § 133.20 sets out the healthcare provider's medical billing procedures.

Denial Reasons

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

- 5721 – To avoid duplicate bill denial for all reconsiderations/adjustments/additional payment requests, submit a copy of this EOR or clear notation.
- 90202 & B13 – Previously Paid. Payment for this claim/service may have been provided in a previous payment.
- 247 - A payment or denial has already been recommended for this service.
- 90438 & 197 – Payment denied/reduced for absence of precertification/authorization.
- 5740 – Pre-Auth is required. If services have been pre-authorized resubmit the bill with authorization information for reconsideration.

Issues

1. Did the requestor bill for a functional capacity evaluation (FCE) or a physical performance test?
2. Are the insurance carrier's denial based on reasons code 90438, 197 and 5740 supported?
3. Is the requestor entitled to reimbursement for the service in dispute?

Findings

1. The requestor seeks medical fee dispute resolution for CPT code 97750-GP (X 8) rendered on September 27, 2021.

   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."

Per CMS' Billing and Coding: Outpatient Physical and Occupational Therapy Services, Article ID A56566, effective October 1, 2020:

> These tests and measurements are beyond the usual evaluation services performed. Examples of physical performance tests or measurements include isokinetic testing, Functional Capacity Evaluation (FCE) and Tinetti. This code may be used for the 6-minute walk test, with a computerized report of the patient's oxygen saturation levels with increasing stress levels, performed under a PT or OT plan of care on pulmonary rehabilitation patients.
>
> The therapy evaluation and re-evaluation codes are for a comprehensive review of the patient including, but not limited to, history, systems review, current clinical findings, establishment of a therapy diagnosis, and estimation of the prognosis and determination and/or revision of further treatment. CPT 97750 is intended to focus on patient performance of a specific activity or group of activities (CPT Assistant, December 2003).
>
> There must be written evidence documenting the problem requiring the test, the specific test performed, and a separate measurement report. This report may include torque curves and other graphic reports with interpretation.
>
> 97750 should not be used to bill for patient assessments/re-assessments such as ROM testing or manual muscle testing completed at the start of care (as this is typically part of the examination included in the initial evaluation) and/or as the patient progresses through the episode of treatment…

Documentation Requirements (required at least every 10 visits) for 97750

- Problem requiring the test and the specific test performed
- Separate measurement report, including any graphic reports
- Application to functional activity
- How the test impacts the plan of care

A review of the submitted reports finds the requestor documented and billed for CPT Code 97750-GP, a physical performance test.

2. The requestor state in pertinent part, "A maximum of 3 PPE'S For each compensable injury shall be billed and reimbursed."

   28 TAC § 133.20(c) states, "A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills."

   The requestor is referencing provisions for Functional Capacity Evaluation's (FCEs) found in 28 TAC §134.225 that limit the number of three FCEs for each compensable injury. This rule also states, "FCEs shall be billed using CPT code 97750 with modifier "FC."

   A review of the submitted medical bill finds the requestor billed for a physical performance test with CPT code 97750-GP not a functional capacity evaluation, CPT code 97750-FC. Because the requestor billed with the "GP" modifier the disputed service is considered a physical therapy service applicable to 28 TAC §134.203 and §134.600, not §134.225.

28 TAC §134.600(p)(5)(A)(i-ii) 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."

3. The DWC finds the requestor did not meet the requirements of 28 TAC §134.600 (p)(5). As a result, the insurance carrier's denial reasons are supported. Reimbursement is therefore, 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.

The DWC finds the requester has established that reimbursement is not 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

		May 24, 2022
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 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.