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

General Information

Requestor Name
PEAK INTEGRATED HEALTHCARE

Respondent Name
OLD REPUBLIC INSURANCE COMPANY.

MFDR Tracking Number
M4-22-1157-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
February 15, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 29, 2021and August 26, 2021	CPT Code 97750-GP (X7) Physical Performance Evaluation (PPE)	$843.78	$664.60
	Total	$843.78	$664.60

Requestor's Position

"The Maximum Allowable Reimbursement (MAR) for Workers' Compensation is configured by the Conversion Factor (which is a combination of the Medicare and DWC Conversation Factors.) multiplied by the Participating Provider fee. Please see attached fee schedule. The charge does not exceed the fee schedule."

Amount in Dispute: $843.78

Respondent's Supplemental Position

"The provider submitted documentation that supports the billing of an FCE exam and not a PPE exam. The provider has met all the components of the FCE exam and therefore must adhere to the billing requirements as outlined below under 134.204(g) and append the required modifier 'FC', the provider has appended the modifier 'GP' in error. As you are aware Texas is a no downcode state and for the reason the providers billing of 97750-GP was appropriately denied as the provider failed to append the required modifier of 'FC.'…"

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 §134.203 sets out the fee guidelines for professional services.
4. 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:

- 112-Payment adjusted as not furnished directly to the patient and/or not documented.
- 119-Benefit maximum for this time period or occurrence has been reached.
- 183-The charge for this procedure exceeds the unit value and/or the multiple procedure rules.
- 90403 – Payment adjusted as not furnished directly to the patient and/or not documented.
- 5271-To avoid duplicate bill denial for all reconsiderations/adjustments/additional payment requests submit a copy of this EOR or clear notation that a recon
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim

Issues

1. Is the insurance carrier's denial based on reason code 112 supported?
2. Is the insurance carrier's denial based on reason code 119 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 (X7) rendered on July 29 and August 26, 2021 in the amount of $843.78.

   The respondent denied both tests based upon "112-Payment adjusted as not furnished directly to the patient and/or not documented."

   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.
>
> CPT code 97750 is not covered on the same day as CPT codes 97161-97168 (due to CCI edits).
>
> **Supportive 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, physical performance exam, not a functional capacity evaluation. As a result, the insurance carrier's denial reason is not supported.

2. The respondent also denied both exams based on "119-Benefit maximum for this time period or occurrence has been reached."

   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 the physical performance test with CPT code 97750-GP not 97750-FC. Because the requestor billed with the "GP" modifier, the DWC finds that the insurance carrier's denial reason is not supported. The requestor is therefore entitled to reimbursement for the service in dispute.

3. 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…"

On the disputed dates of service, July 29, 2021, and August 26, 2021 the requestor billed CPT code 97550-GP (X 7). 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.

a. The dates of service are July 29, 2021 and August 26, 2021.
b. MPPR rates are published by carrier and locality.
c. Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 75043; therefore, the Medicare locality is "Dallas, Texas."
d. The Medicare participating amount for CPT code 97750 at this locality is $35.06 for the first unit, and $25.75 for subsequent units.
e. The DWC conversion factor for 2021 is 61.17
f. The Medicare conversion factor for 2021 is 34.8931.

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 x 6 units = $270.84 for the subsequent units, for a total of $332.30. The respondent paid $0.00. The difference between the MAR and amount paid is $332.30 x 2 = a total recommended amount of $664.60; this amount is recommended for reimbursement.

4. The DWC finds the requestor is entitled to a total recommended amount of $664.60. Therefore, this amount is 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 in the amount of $664.60 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor $664.60 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

______________________	______________________	May 20, 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.