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
ARCH INDEMNITY INSURANCE COMPANY

MFDR Tracking Number
M4-22-1946-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
May 9, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 2, 2021	97750-GP x 8 units Physical Performance Test	$482.16	$383.37
	Total	$482.16	$383.37

Requestor's Position

"The Patient was referred for a Physical Performance Evaluation for an initial to determine patients' physical abilities. Patient completed several activities to figure out strength requirements. Please see attached report regarding patients results of her physical activity abilities. Denial reasons are ridiculous, patient was in the office and present for this evaluation. Please see attached FIRST RECONSIDERATION that was sent to the carrier explaining patients' evaluation. IF THESE CLAIMS ARE NOT PAID IN FULL, EVERYTHING WILL BE SENT TO MFDR FOR FURTHER ACTION. This is an approved case, and all claims are to be paid in full."

Amount in Dispute: $482.16

Respondent's Position

"The service in question is a Functional Capacity Evaluation. The Provider billed $482.16. The Provider is seeking reimbursement in that amount. We are attaching a copy of the Carrier's initial EOB dated December 8, 2021. The Carrier's reasons for denying the bill arc set out on that EOB. The Carrier's position remains the same. The Provider is not entitled to reimbursement."

Response Submitted by: Flahive, Ogden & Latson

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 fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.

Denial Reasons

The insurance carrier reduced or denied the 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.
- 90403 – PAYMENT ADJUSTED AS NOT FURNISHED DIRECTLY TO THE PATIENT AND/OR NOT DOCUMENTED.
- 90950 – THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL. ALLOWANCE AMOUNTS REFLECT ANY CHANGES TO THE PREVIOUS PAYMENT.
- 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.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 163 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE UNIT VALUE AND/OR THE MULTIPLE PROCEDURE RULES.

Issues

1. Are the Insurance Carrier's denial reasons supported?
2. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 97750-GP rendered on November 2, 2022. The insurance carrier denied/reduced the service in dispute with reduction codes indicated above. The insurance carrier states in pertinent part, "The service in question is a Functional Capacity Evaluation. The Provider billed $482.16. The Provider is seeking reimbursement in that amount."

   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 (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes "

The requestor appended the "GP" modifier to the disputed code. 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.

The DWC finds that the requestor billed and documented a physical performance test. As a result, the insurance carrier's denial reasons are not supported, and the requestor is entitled to reimbursement pursuant to 28 TAC §134.203.

2. The fee guidelines for disputed service 97750-GP (x 8) is found at 28 TAC §134.203.

   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, the requestor billed CPT code 97550-GP (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.

- The date of service is November 2, 2021.
- 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 76112 which is located in Fort Worth, Texas; therefore, the Medicare locality is "Fort Worth, Texas."
- The Medicare participating amount for CPT code 97750 at this locality is $35.50 for the first unit, and $26.17 for subsequent units.
- The DWC conversion factor for 2021 is 61.17
- 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 $62.23 for the first unit, and $45.88 x 7 units = $321.14 for the subsequent units, for a total of $383.37. The respondent paid $0.00. The difference between the MAR and amount paid is $383.37; this amount is recommended for reimbursement.

The DWC finds that the requestor is entitled to reimbursement in the amount of $383.37.

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 of $383.37 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 $383.37 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 3, 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.