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
XL SPECIALTY INSURANCE COMPANY

MFDR Tracking Number
M4-22-2001-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
May 13, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 15, 2001 and February 9, 2022	97750-GP (x 8 units) x 2	$984.24	$762.89
	Total	$984.24	$762.89

Requestor's Position

"The patient has had NO other PPE for this injury. And we have received no payment for this date of service. The fee schedule allows for $482.16 to be charged for PHYSICAL PERFORMANCE EVALUATION that lasts 2 hours (8 units). 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: $984.24

Respondent's Position

"The bill(s) in question was escalated and the review has been finalized. Our bill audit company has determined additional monies are owed. Attached is a copy of the EOB and payment summaries, which includes interest... Our bill audit company stands on their original review. Below is an explanation from our bill review vendor: CV has determined the denials to be correct and no monies are due to the provider for the disputed Dates of Service..."

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 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.
3. 28 TAC §134.225, effective July 7, 2016, sets the reimbursement guidelines for FCEs.

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 reconsideration/adjustments/additional payment requests submit a copy of this EOR
- 90403 & 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.
- 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules.
- 257 – A payment or denial has already been recommended for this service.
- 90202 & B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 90950 – This bill is a reconsideration of a previously reviewed bill allowance amounts reflect any changes to the previous payment.

Issues

1. Is the Insurance Carrier's denial reason90403 & 112 supported?
2. Is the insurance Carrier's denial reason 119 & 163 supported?
3. Does the multiple procedure payment reduction apply to CPT Code 97750-GP?
4. Is the Requestor entitled to reimbursement for CPT Code 97750-GP?

Findings

1. The requestor seeks reimbursement for CPT Code 97750-GP rendered on December 15, 2021 and February 9, 2022. The insurance carrier denied/reduced the disputed service with denial reduction codes:
    - 90403 & 112 – Payment adjusted as not furnished directly to the patient and/or not documented

    28 TAC §134.203(b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

CPT Code 97750-GP is defined 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

The DWC finds that the requestor billed and documented a physical performance test on December 15, 2021 and February 9, 2021. As a result, the insurance carrier's denial reasons are not supported.

2. The insurance carrier denied the disputed CPT Codes with denial reduction codes:
   - 119 – Benefit maximum for this time period or occurrence has been reached.
   - 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rule.

28 TAC §134.225 states, "The following applies to functional capacity evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a division ordered test; a maximum of two hours for an interim test; and a maximum of three hours for the discharge test unless it is the initial test. Documentation is required.

The DWC finds that the requestor did not bill for CPT Code 97750-FC which does have a benefit maximum set out in 28 TAC §133.225. The requestor however, billed CPT Code 97750-GP. 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.

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

   28 TAC §134.203 (c) states, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications…"

   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 December 15, 2021.
- The DWC conversion factor for 2021 is 61.17
- The Medicare conversion factor for 2021 is 34.8931.
- 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; therefore, the Medicare locality is "Dallas, Texas."
- The Medicare participating amount for CPT code 97750 at this locality is $35.06 for the first unit, and $25.75 for subsequent units.

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 7 units = $315.99 for the subsequent units, for a total of $377.45. The respondent paid $0.00. The difference between the MAR and amount paid is $377.45; this amount is recommended.

The MPPR Rate File that contains the payments for 2022 services is found at https://www.cms.gov/Medicare/Billing/TherapyServices/index.html.

- The date of service is February 9, 2022.
- The DWC conversion factor for 2022 is 62.46
- The Medicare conversion factor for 2022 is 34.6062.
- 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; therefore, the Medicare locality is "Dallas, Texas."
- The Medicare participating amount for CPT code 97750 at this locality is $34.77 for the first unit, and $25.54 for subsequent units.

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 $62.76 for the first unit, and $46.10 x 7 units = $322.68 for the subsequent units, for a total of $385.44. The respondent paid $0.00. The difference between the MAR and amount paid is $385.44; this amount is recommended.

4. The DWC finds that the requestor is entitled to a total reimbursement in the amount of $762.89. 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 of $762.89 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 $762.89 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 16, 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.