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
ZURICH AMERICAN INSURANCE COMPANY

MFDR Tracking Number
M4-22-2264-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
June 20, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 2, 2022 and March 31, 2022	99204 and 97750-GP	$808.40	$385.44
	Total	$808.40	$385.44

Requestor's Position

"The patient has had only 1 other PPE for this injury. And we have received no payment for this date of service. owe rule 134.204(9) A maximum of 3 PPE'S for each compensable injury shall be billed and reimbursed."

Amount in Dispute: $808.40

Respondent's Position

"Date of Service 03/02/2022... The documents do not support the level of service billed by the provider... Documentation must support A Moderate number and complexity of the problems addressed, A Moderate amount or complexity of the data analyzed, and/ or a Moderate Risk of Complications. 2 out of 3 of these requirements must be met... Date of Service 03/31/2022... After review, we have determined that the provider is due additional allowance. The charges have been reprocessed and the adjustment has been finalized. Case ID#... (allowed $385.46)."

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.

Denial Reasons

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

- 5407 - RECONSIDERATION NO ADDITIONAL ALLOWANCE RECOMMENDED THIS BILL AND SUBMITTED DOCUMENTATION HAVE BEEN RE-EVALUATED BY CLINICAL VALIDATION.
- 5721 - TO AVOID DUPLICATE BILL DENIAL FOR ALL RECONSIDERATIONS/ ADJUSTMENTS/ ADDITIONAL PAYMENT REQUESTS SUBMIT A COPY OF THIS EOR.
- 6249 - AFTER REVIEW OF THE BILL AND THE MEDICAL RECORD THIS SERVICE IS BEST DESCRIBED BY 99203. SUBMITTED DCUMENTATION DID NOT MEET AT LEAST 2 OF
- 90168 - PAYMENT ADJUSTED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE.
- 90563 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROESSED PROPERLY.
- 5283 – ADDITIONAL ALLOWANCE IS NOT RECOMMENDED AS THIS BILL WAS REVIEWED IN ACCORDANCE WITH STATE GUIDELINES, USUAL AND CUSTOMARY POLICIES.

Issue

1. Did the insurance carrier issue a payment for CPT Code 97750-GP?
2. Is the insurance carrier's denial reason supported for CPT Code 99204?
3. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 97750-GP rendered on March 31, 2022 The insurance carrier denied/reduced the disputed service with denial reduction codes indicated above.

   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 (e.g., 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.
>
> **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. 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 99204 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…"

CPT code 99204 is defined as, "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family."

The division finds the submitted report does not sufficiently support a comprehensive history, that is required for billing code 99204; therefore, reimbursement is not recommended.

The DWC finds that the requestor is not entitled to reimbursement for the disputed services

3. 28 TAC §134.203 states in pertinent part, "(c) 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. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) 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..."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

   - The 2022 DWC Conversion Factor is 62.46
   - The 2022 Medicare Conversion Factor is 34.6062
   - Per the medical bills, the services were rendered in zip code 75043; 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 the subsequent units.

   - Using the above formula, the DWC finds the MAR is $62.76 for the first unit and $322.68 for the 7 subsequent units.
   - The respondent paid $0.00.
   - Reimbursement of $385.44 is recommended for CPT Code 97750-GP.

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 $385.44 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 $385.44 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	_____	July 29, 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.