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
HARTFORD CASUALTY INSURANCE CO.

MFDR Tracking Number
M4-22-2341-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
June 30, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 10, 2022	97750-GP	$502.08	$0.00
	Total	$502.08	$0.00

Requestor's Position

"The patients treating doctor referred the patient for a PPE. This provider is an authorized treater in workers' compensation. The treating doctor referred the patient to our provider to have the PHYSICAL PERFORMACE EVALUATION. Please see office visit note and referral attached. Also, this is the patient's 1st PPE for this injury."

Amount in Dispute: $502.08

Respondent's Position

"Please accept this letter as a response to the above dispute. Bill was processed and denied as not authorized by adjuster's response: That was for an FCE, I don't see ur · approved it. Below is what doesn't require pre-auth, FCE always require It."

Response Submitted by: The Hartford

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 §134.600, effective November 1, 2018, requires preauthorization for specific treatments and services.
3. 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:

- 133 – The disposition of this claim/service is pending further review.
- AUTH – Payment denied/reduced for absence of or exceeded pre-certification/authorization. Pre-authorization was not obtained, and treatment was rendered without the approval of treating doctor.
- 96 – Non-covered charge(s).
- NABA – Reimbursement is being withheld as the treating doctor and/or services rendering were not approved based upon handler review.

Issues

1. What services did the requestor bill?
2. Is the Insurance Carrier's denial reason(s) supported?
3. Is the Requestor entitled to reimbursement for CPT Code 97750-GP?

Findings

1. The requestor seeks reimbursement for CPT Code 97750-GP rendered on May 10, 2022.

   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 CPT Code 97750. 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, which is considered a physical therapy service, not a Functional Capacity Evaluation. The DWC will now determine if preauthorization was required for the physical performance test.

2. The insurance carrier denied/reduced the disputed service due to lack of preauthorization and include a copy of a document to support that preauthorization was required, however the document that was part of the insurance carrier's position summary was illegible.

   Per 28 TAC §134.600 (p)(5) 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."

The DWC finds that the physical therapy service, billed under 97750-GP, requires preauthorization per 28 TAC §134.600. The requestor did not submit a preauthorization report to support that preauthorization was obtained; therefore, the respondent's denial is supported.

3. The DWC finds that the requestor was required to obtain preauthorization for the physical therapy service. The requestor did not include documentation to support that preauthorization was obtained. As a result, $0.00 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 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

		July 22, 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.