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
INDEMNITY INSURANCE COMPANY

MFDR Tracking Number
M4-22-2606-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
August 11, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 14, 2022 through March 28, 2022	99204, 99213 and 97750-GP	$853.90	$737.26
	Total	$853.90	$737.26

Requestor's Position

"The patient is entitled to reasonable medical care as stipulated in Texas law as related to the original injury. Office visits are recommended as determined to be medically necessary. Evaluation and management outpatient visits to the offices of medical doctors play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged."

Amount in Dispute: $853.90

Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed. Supplemental response will be provided once the bill auditing company has finalized their review."

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 §134.203 sets out the fee guideline for professional medical services.
3. 28 TAC §134.204 sets out the Medical Fee Guideline for Workers Compensation Specific Services.

Denial Reasons

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

- 90168 & 150 – Payment adjusted because the payer deems the information submitted does not support this level of service.
- 90223 & P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 4063 – Reimbursement is based on the physician fee scheduled when a professional service was performed in the facility setting.
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
- 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.
- 4063 – Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting.
- 90202 & B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 247 – A payment or denial has already been recommended for this service.

Issues

1. Is the Insurance Carrier's denial reason supported for CPT Code 97750-GP rendered on March 15, 2022?
2. Is the Insurance Carrier's denial reason supported for CPT Code 99213 rendered on March 28, 2022?
3. Is the Insurance Carrier's denial reason supported for CPT Code 99204 rendered on March 14, 2022?
4. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 97750-GP rendered on March 15, 2022. The insurance carrier denied the dispute service with denial reduction codes "90403, 112, 119, and 193."

   Review of the submitted documentation supports that the disputed services were rendered directly to the injured employee. In addition, CPT Code 97750-GP is a physical performance evaluation not a functional capacity evaluation and therefore is not subject to the maximum billable amount of three FCE's per injury, in accordance with 28 TAC, §134.204

   As a result, the insurance carrier's denial reasons are not supported and the requestor is entitled to reimbursement for the disputed service.

2. The requestor seeks additional reimbursement for CPT Code 99213 rendered on March 28, 2022. The insurance carrier issued a payment in the amount of $121.72 and denied the remaining charge with reduction codes, "90223, P12, and 4063."

   Review of the CMS-1500 documents that the dispute service was rendered in an office setting, as documented with place of service code "11." As a result, the DWC finds that the insurance carrier's denial reasons are not supported and the requestor is therefore entitled to additional reimbursement for CPT code 99213, pursuant to 28 TAC §134.203.

3. The requestor seeks reimbursement for CPT Code 99204 rendered on March 14, 2022. The insurance carrier denied the disputed service denial reduction code, "90168, 150, P12, 193, and 4063."

   Review of the CMS-1500 documents that the dispute service was rendered in an office setting, as documented with place of service code "11." As a result, the DWC finds that the insurance carrier's denial reason is not supported.

   The DWC will now consider whether the requestor documented the level of service billed. Review of the office visit documentation supports the level of service billed. As a result, the DWC finds that the insurance carrier's denial reasons are not supported and the requestor is therefore, entitled to reimbursement for CPT code 99204, pursuant to 28 TAC §134.203.

4. The fee guidelines for the disputed services are found at 28 TAC §134.203.

   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."

   The requestor billed CPT Code 97750-GP. The definition of each code is indicated below:

   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 the disputed services. The "GP" modifier is described as "Services delivered under an outpatient physical therapy plan of care."

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.

Review of the Medicare policies finds that the multiple procedure payment reduction (MPPR) applies to the Practice Expense (PE) of certain time-based physical therapy codes when more than one unit or procedure is provided to the same patient on the same day. Medicare publishes a list of the codes subject to MPPR annually. The DWC finds that CPT Codes 97750-GP is subject to the MPPR policy.

CPT Code 97750 was billed with no other CPT Code on March 15, 2022. As a result, the requestor is entitled to the MPFS for the first unit and MPPR applies to the subsequent units billed.

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…"

Reimbursement is calculated per 28 TAC §134.203 for CPT Codes 99213 and 99204.

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
- The services were provided in zip code 75006; therefore, the Medicare locality is "Dallas."

The Medicare Participating amount for CPT code 99204 at this locality is $169.72.

- Using the above formula, the DWC finds the MAR is $306.32.
- The respondent paid $0.00.
- Reimbursement of $306.32 is recommended.

The Medicare Participating amount for CPT code 99213 at this locality is $92.65.

- Using the above formula, the DWC finds the MAR is $167.22.
- The respondent paid $121.72.
- Reimbursement of $45.50 is recommended.

Reimbursement for CPT Code 97750-GP is calculated below.

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

- MPPR rates are published by carrier and locality.
- The services were provided in zip code 75006; therefore, the Medicare locality is "Dallas."
- The 2022 DWC Conversion Factor is 62.46
- The 2022 Medicare Conversion Factor is 34.6062

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

CPT Code	Medicare physician Fee Schedule (MPFS) (1st unit)	MPFS MPPR for subsequent units	MAR (1st unit)	MAR for subsequent units
97750-GP x 8	$34.77	$25.54	$62.76	$46.10 x 7 = $322.68

The DWC finds that the requestor is therefore entitled to reimbursement in the amount of $385.44 for CPT Code 97750-GP.

5. The DWC finds that the requestor is therefore entitled to a total recommended amount of $737.26. 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 of $737.26 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 $737.26 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		January 23, 2023
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.