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 INTERGATED HEALTHCARE

Respondent Name
ARCH INSURANCE COMPANY

MFDR Tracking Number
M4-23-1068-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
January 10, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 29, 2022	97750-GP	$502.08	$385.44
	Total	$502.08	$385.44

Requestor's Position

"The patient has had NO other PPE for this injury. And we have received no payment for this date of service… schedule. All necessary and supporting documentation is included with this reconsideration to properly justify/support the administered treatment still needing to be paid."

Amount in Dispute: $502.08

Respondent's Position

"The provider submitted documentation that supports the billing of an FCE exam and not a PPE exam. The provider has met all the components of the FCE exam and therefore must adhere to the billing requirements as outlined below under 134.204 (g) and append the required modifier "FC", the provider has appended the modifier "GP" in error. As you are aware Texas is a no down code state and for the reason the providers billing of 977S0-G P was appropriately denied as the provider failed to append the required modifier of "FC". By not appending the required modifier "FC", the provider is able to circumvent the FCE limitations as outlined below… Previous PPE was performed on 08/30/2022, the provider is not due any additional monies at this time."

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 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:

- 90403 & 112 – SERVICE NOT FURNISHED DIRECTLY TO THE PATIENT AND/OR NOT DOCUMENTED.
- 119 – BENEFIT MAXIMUM FOR THIS PERIOD OR OCCURNCE HAS BEEN REACHED.
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW IT WAS DETERMIED THAT THIS CLAIM WAS PROCESSED PROPERLY.

Issues

1. Did the Insurance Carrier support their denial reason(s)?
2. Is the Requestor entitled to reimbursement for CPT Code 97750-GP?

Findings

1. The requestor seeks reimbursement for CPT Code 97750-GP rendered on September 29, 2022. The insurance carrier denied/reduced the disputed service with denial reduction codes indicated above.

   The insurance carrier states, "The provider submitted documentation that supports the billing of an FCE exam and not a PPE exam."

   The DWC will determine if the Requestor billed in accordance with 28 TAC §134.203.

   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 the disputed CPT code. 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 and appended the appropriate modifier of "GP." The insurance carrier did not support that the Requestor exceeded the fee guideline by the number of tests or the amount of time allowed for the test; therefore, the Respondent's denial reasons are not supported. The disputed service is therefore reviewed pursuant to the applicable rules and guidelines.

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 97550-GP (x 8). The DWC finds that Medicare's Multiple Procedure Payment Reduction (MPPR) discounting rule 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 2022 services is found at https://www.cms.gov/Medicare/Billing/TherapyServices/index.html.

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

- MPPR rates are published by carrier and locality.
- The date of service was rendered in 2022.
- The DWC conversion factor for 2022 is 62.46
- The Medicare conversion factor for 2022 is 34.6062.
- Review of Box 32 of the CMS-1500 finds that the services were rendered in zip code 75043; therefore, the Medicare locality is "Dallas."
- The Medicare participating amount for CPT 97750 at this locality is $34.77 for the first unit, and $25.54 for each of the 7 subsequent units.
- Using the above formula, the DWC finds the MAR is $62.76 for the first unit, and $46.10 x 7 units, for a total of $322.68 for the subsequent 7 units.
- The MAR is $385.44.
- The Insurance carrier paid $0.00
- The requestor is entitled to reimbursement in the amount of $385.44.

3. The DWC finds that the requestor is entitled to reimbursement in the amount of $385.44.

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, the 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

		April 10, 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.