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
Arch Indemnity Insurance Co.

MFDR Tracking Number
M4-23-1073-01

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
October 10, 2022	Physical Performance Evaluation 97750-GP	$502.08	$502.05

Requestor's Position

This date of service was denied payment stating "benefit maximum has been reached, or exceeds unit value or mppr rules."

This is incorrect**. The patient has had NO other PPE for this injury. And we have received no payment for this date of service. DWC rule 134.204(g)** The fee schedule allows for $**502.08** 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 … multiplied by the Participating Provider fee. **The charge does not exceed the fee schedule.**

Amount in Dispute: $502.08

Respondent's Position

Initial Position Statement (January 25, 2023):

Our initial response to the above referenced medical fee dispute is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed.

Response Submitted by: Gallagher Bassett

Subsequent Position Statement (February 6, 2023):

The provider is not entitled to reimbursement as noted in the denial language on the EOBs.

Response Submitted by: Flahive, Ogden & Latson

Subsequent Position Statement (March 1, 2023):

Our bill audit company has determined that additional monies are owed in the amount of $385.40 . Interest in the amount of $4.62 has been added.

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 §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.203 sets out the fee guidelines for professional medical services.

Denial Reasons

The insurance carrier 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 time period or occurrence has been reached.
- 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules.
- 193 – Original payment decision is being maintained. Upon, review, it was determined that this claim was processed properly.

Issues

1. Were Zurich American Insurance Co.'s denial reasons supported?

2. Is Peak Integrated Healthcare entitled to additional reimbursement?

Findings

1. Peak Integrated Healthcare is seeking reimbursement for a physical performance evaluation performed on October 10, 2022. Peak Integrated Healthcare billed the disputed service using only code 97750-GP.

   Procedure code 97750 is defined as: "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes." Modifier "GP" is defined as "Services delivered under an outpatient physical therapy plan of care."

   The division finds that procedure code 97750-GP is a professional medical service, subject to the fee guidelines found in 28 TAC §134.203.

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

   The insurance carrier's denials and the division's responses are found below:

   - *90403 (112) – Service not furnished directly to the patient and/or not documented*:

     The division finds that the greater weight of the submitted documentation supports that the services in question were furnished directly to the injured employee.

     Per CMS Local Article A56566: "Billing and Coding: Outpatiend Physical and Occupational Therapy Services,"

     > 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.

     Submitted documentation includes the criteria required by CMS for billing and coding. This denial reason is not supported.

   - *119 – Benefit maximum for this time period or occurrence has been reached* and *163 - The charge for this procedure exceeds the unit value and/or the multiple procedure*

rules:

No evidence was provided to support that any procedure code other than 97750-GP was billed for this injured employee on this date of service. Therefore, multiple procedure rules do not apply.

Billing for the services in question was for eight units. Documentation submitted indicates that the evaluation was performed over a period of two hours. As noted above, 15 minutes represents one unit for this procedure code.

The division concludes that the charge for this procedure code does not exceed the unit valued documented. The insurance carrier's denial for this reason is not supported.

2. Because Zurich American Insurance Co. failed to support its denial reasons, the division finds that Peak Integrated Healthcare is entitled to reimbursement.

   Per 28 TAC §134.203 (c), the maximum allowable reimbursement (MAR) for professional services is determined by applying the Medicare payment policies with minimal modifications. Conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index 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).

   For date of service October 10, 2022:

   - The 2022 DWC Conversion Factor is $62.46
   - The 2022 Medicare Conversion Factor is 34.6062
   - Per the medical bills, the service was rendered in zip code 75211 which is in Medicare locality 0441211.
   - The Medicare Participating Amount for CPT code 97750 at this locality is $62.76.

   Using the above formula, the division finds the MAR for eight units is $502.05. 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.

DWC finds the requester has established that additional reimbursement of $502.05 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Zurich American

Insurance Co. must remit to Peak Integrated Healthcare $502.05 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		March 15, 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.