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 Co. of North America

MFDR Tracking Number
M4-23-1340-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
February 8, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 21, 2022	Physical Performance Evaluation 97750-GP	$502.08	$385.44

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 1 other PPE for this injury … The charge does not exceed the fee schedule.**

Amount in Dispute: $502.08

Respondent's Position

The carrier has denied reimbursement and relies upon its EOBs.

Response Submitted by: Flahive, Ogden & Latson

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.
- 90950 – This bill is a reconsideration of a previously reviewed bill. Allowance amounts reflect any changes to the previous payment.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is the insurance carrier's denial of payment 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 November 21, 2022. Peak Integrated Healthcare billed the disputed service using procedure 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 (c), the maximum allowable reimbursement (MAR) for professional services is determined by applying the Medicare payment policies with minimal modifications.

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: Outpatient 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 a focus on patient performance. 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*:

  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 insurance carrier's denial for this reason is not supported.

2. Because the insurance carrier failed to support its denial of payment, Peak Integrated Healthcare is entitled to reimbursement.

   Per Medicare Claims Processing Manual (cms.gov), Chapter 5, 10.7, effective February 6, 2019:

   > Medicare applies a multiple procedure payment reduction (MPPR) to the practice expense (PE) payment of select therapy services. The reduction applies to the HCPCS codes contained on the list of "always therapy" services …
   >
   > Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure …
   >
   > Full payment is made for the unit or procedure with the highest PE payment … 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.

Procedure code 97550 is classified as "always therapy" in the 2022 Therapy Code List and Dispositions found at Annual Therapy Update | CMS and has a value of "5" on the MFSD. Therefore, the MPPR applies to the reimbursement of this code.

Per the MFSD, the following information is used to calculate the Medicare payment for procedure code 97750 on November 1, 2022:

- Per the submitted medical bills, the service was rendered in zip code 75211 which is in Medicare locality 0441211.
- The Work RVU was 0.450 with GPCI adjustment of 1.023.
- The PE RVU was 0.520 with GPCI adjustment of 1.026. Subsequent units are calculated with PE RVU 0.260 with GPCI adjustment of 1.026.
- The MP RVU was 0.020 with GPCI adjustment of 0.546.
- The Medicare Participating Amount for CPT code 97750 at this locality is $62.76 for the first unit and subsequent units is $25.47.

28 TAC §134.203 (c)(1) and (2) states that DWC 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 for the first unit, the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) x Medicare Participating Amount.

- The 2022 DWC Conversion Factor is $62.46
- The 2022 Medicare Conversion Factor is $34.6062

The MAR for the first unit is $62.76. The MAR for each subsequent unit is $46.10. For eight total units, the MAR is $385.44. 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 $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 Indemnity Insurance Co. of North America must remit to Peak Integrated Healthcare $385.44 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		April 14, 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.