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
AMERICAN ZURICH INSURANCE COMPANY

MFDR Tracking Number
M4-23-1760-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
March 20, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 16, 2023	97750-GP Physical Performance Test	$531.04	$404.25
	Total	$531.04	$404.25

Requestor's Position

"This is incorrect. The patient has had no other PPE for this injury. And we have received no payment for this date of service owe rule 134.204(g). The fee schedule allows for $531.04 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 (which is a combination of the Medicare and DWC Conversation Factors.) multiplied by the Participating Provider fee. The charge does not exceed the fee schedule."

Amount in Dispute: $531.04

Respondent's Position

"The original request submitted by Peak Integrated Healthcare on January 20, 2023, was denied because the service was not documented. The service in dispute was not performed for the compensable injury… Per Rule 133.307(f)(3)(C) the MFDR should be dismissed due to an unresolved issue of extent of injury."

Response Submitted by: Ricky D. Green, PLLC

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.

Denial Reasons

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

- 90403 & 112 - Services not furnished directly to the patient and or not documented.
- 119 – Benefit maximum for this period or occurrence has been reached.
- P12 – Workers' compensation jurisdictional fee scheduled adjustment.
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

Issues

1. Did the insurance carrier raise a new issue or defense after the filing of the MDR?
2. Are the Insurance Carrier's denial reasons supported?
3. Is the Requestor entitled to reimbursement?

Findings

1. Rule §133.307(d)(2)(F) requires that: The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

   Review of the submitted information finds insufficient documentation to support an EOB was presented to the health care provider giving notice of the extent of injury denial reason or defenses raised in the insurance carrier's response to MFDR.

   Pursuant to Rule §133.307(d)(2)(F), the insurance carrier's failure to give notice to the health care provider of specific codes or explanations for reduction or denial of payment as required by Rule §133.240, the DWC finds the respondent has raised new denial reasons or defenses. The carrier failed to give notice to the health care provider during the medical bill review process or before the filing of this dispute. Consequently, the division concludes the insurance carrier has waived the right to raise a new denial reason or defense during dispute resolution. Any such new defenses or denial reasons will not be considered in this review.

2. The requestor seeks reimbursement for CPT Code 97750-GP rendered on January 16, 2023. The insurance carrier denied the service in dispute with reduction codes indicated above.

   The insurance carrier states in pertinent part, "The original request submitted by Peak Integrated Healthcare on January 20, 2023, was denied because the service was not documented."

   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."

   CPT code 97750 is described as, "Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes."

   The requestor appended the "GP" modifier to the disputed code. The "GP" modifier is described as, "Services delivered under an outpatient physical therapy plan of care."

   Based upon the code and modifier description, CPT code 97750-GP is an outpatient physical therapy service.

   Payment denial 90403 & 112 indicates that the services were not furnished directly to the patient and/or not documented. Review of the medical documentation supports that the services were rendered to the injured employee and documented as billed. The insurance carrier's denial reason is not supported.

   Payment denial 119 indicates that the benefit maximum for this time period or occurrence has been reached, and the charge for this procedure exceeds the unit value and/or the multiple procedure rules. The requestor billed CPT Code 97750-GP which indicates that the service rendered in a physical performance test. The requestor did not bill for an FCE which does have a benefit maximum; in accordance with 28 TAC §134.225. Because the requestor appended modifier -GP, the DWC finds that the disputed services are subject to Medicare's multiple procedure payment reductions (MPPR) policy.

   The DWC finds that the insurance carrier's denial reasons are not supported. The requestor billed and documented a physical performance test and, therefore the requestor is entitled to reimbursement for the CPT Code 97750-GP.

3. 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…"

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.

On the disputed date of service, the requestor billed CPT code 97550-GP (x8). The multiple procedure rule discounting applies to the disputed service.

The MPPR Rate File that contains the payments for 20223 services is found at https://www.cms.gov/Medicare/Billing/TherapyServices/index.html.

- The date of service was rendered in 2023.
- MPPR rates are published by carrier and locality.
- Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 75211; therefore, the Medicare locality is "Dallas."

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

- The DWC conversion factor for 2023 is 64.83.
- The Medicare conversion factor for 2023 is 33.8872.
- The Medicare participating amount for CPT code 97750 at this locality is $34.70 for the first unit, and $25.23 for subsequent units.
- Using the above formula, the MAR is $66.38 for the first unit, and $48.27 x 7 units = $337.87 for the subsequent units, for a total MAR of $404.25.
- The respondent paid $0.00.
- The requestor seeks $531.04.
- The difference between the MAR and amount paid is $404.25; this amount is recommended for reimbursement.

The DWC finds that the requestor is entitled to reimbursement in the amount of $404.25.

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 $404.25 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 $404.25 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

______________________	______________________	August 1, 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.