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
National Union Fire Ins Co of Pittsb PA

MFDR Tracking Number
M4-23-2092-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
April 26, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 28, 2023	97750-GP	$531.04	$404.22
	Total	$531.04	$404.22

Requestor's Position

The requestor did not submit a position statement with this request for MFDR but did submit a copy of their reconsideration that states, "We don't agree that benefit maximum has been reached."

Amount in Dispute: $531.04

Respondent's Position

"Our bill audit company has determined no further payment is due. The rationale… The provider submitted documentation that supports the billing of an FCE exam and not a PPE exam."

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 guidelines for the resolution of medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out billing and fee guidelines for workers' compensation specific services.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.

Denial Reasons

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

- 112 – Service not furnished directly to the patient and/or not documented
- 119 – Benefit maximum for this time period or occurrence has been reached
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Is the respondent's position statement supported?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. What is the rule applicable to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent states in their position statement, "The provider submitted documentation that supports the billing of an FCE exam…"

   DWC Rule §134.204(g) states in pertinent part, FCEs shall be billed using CPT Code 97750 with modifier "FC." The submitted medical bill did not include 97750 -FC. The requestor's position statement is not supported.

2. The requestor is seeking reimbursement for Code 97750 – "Physical performance test or measurement (eg musculoskeletal functional capacity) with written report, each 15 minutes" with the modifier GP – "Services delivered under an outpatient physical therapy plan of care" rendered on February 28, 2023. The carrier denied the service as not being documented and benefit maximum.

Review of the submitted letter from the evaluator dated February 28, 2023 indicates the injured worker's name and results of testing. The denial of lack of documentation is not supported.

The denial for benefit maximum is also not supported as this code and modifier do not have a limit of benefits in applicable DWC rules and fee guidelines. The service in dispute will be reviewed per applicable fee guideline.

3. The applicable DWC fee guideline for dispute code is 28 TAC §134.203 (b) (1) which requires the application of Medicare payment policies applicable to professional services.

   The Medicare 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.

   The MPPR policy allows for full payment for the unit or procedure with the highest Practice Expense (PE) payment factor and for subsequent units the Practice Expense (PE) payment factor is reduced by 50 percent.

   The *MPPR Rate File* that contains the payments for 2023 services is found at www.cms.gov/Medicare/Billing/TherapyServices.

   - MPPR rates are published by carrier and locality.
   - The services were provided in Garland, Texas.
   - The carrier code for Texas is 4412 and the locality code for Garland is 11.
   - First unit allowable $33.86.
   - Second through eighth units allowable $24.61.

   The following formula represents the calculation of the DWC MAR at §134.203(c)(1)& (2).

   (DWC Conversion Factor ÷ Medicare Conversion Factor) x Medicare Payment = MAR

   - 64.83/33.06 x $33.86 = $66.40
   - 64.83/33.06 x $24.61 x 7 = $337.82
   - Total MAR $404.22

4. The total allowable DWC fee guideline reimbursement is $404.22. This amount is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has established payment 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 National Union Fire Ins Co of Pittsb PA must remit to Peak Integrated Healthcare $404.22 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		May 26, 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 in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

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