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
National Union Fire Insurance Co. of Pittsb PA

MFDR Tracking Number
M4-23-2154-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
May 2, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
02/27/2023	97750-GP	$531.04	$404.25
	Total	$531.04	$404.25

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. DWC rule 134.204(g) The fee schedule allows for $531.04 to be charged for PHYSICAL PERFORMANCE EVALUATION that lasts 2 hours (8 units)... We disagree that the benefit maximum has been reached..."
Amount in Dispute: $531.04

Respondent's Position

"... The EOB denied the medical bill for several reasons. The services were not documented. The benefit maximum for this period or occurrence has been reached. It is the carrier's position that the provider is not entitled to any reimbursement... "
Response Submitted by: National Union Fire Insurance Co. of Pittsb. PA

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 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.

Adjustment 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.
- 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.
- 90950 – This bill is a reconsideration of a previously reviewed bill, allowance amounts reflect any changes to the previous payment.

Issues

1. Is the Insurance Carrier's (IC) denial reason supported?
2. Is the Requestor entitled to reimbursement for CPT Code 97750-GP?

Findings

1. The IC denied disputed service billed as CPT Code 97750-GP rendered on February 27, 2023. The insurance carrier denied the disputed service with reason codes 112 and 119 (description indicated above).

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

The requestor appended the "GP" modifier to code 97750. 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.

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

Review of submitted medical documentation finds that the healthcare provider documented a 2-hour physical performance evaluation on the same injured employee that is indicated on the medical bill. Review of documentation submitted finds that the requester is in compliance with documentation requirements outlined above.

There is no evidence submitted to indicate that the benefit maximum for this service had been reached.

The division finds that the IC's denial reasons 112 and 119, described above, are not supported.

2. The requester is seeking reimbursement for 8 units of CPT code 97750-GP rendered on February 27, 2023.

The division finds that 28 TAC §134.203 applies to the reimbursement of 97750-GP.

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."

28 TAC §134.203 (c)(1) states, "To determine the maximum allowable reimbursement (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 (MPPR) 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 division finds that the MPPR rule applies to CPT code 97750-GP.

On the disputed date of service, the requester billed CPT code 97750-GP x8 units.

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

To determine the maximum allowable reimbursement (MAR) the following formula is used:
(DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = MAR.

- MPPR rates are published by carrier and locality.
- The disputed date of service is February 27, 2023
- The disputed service was rendered in zip code 75211, locality 11, Dallas; carrier 4412.
- The Medicare participating amount for CPT code 97750 in 2023 at this locality is $34.70 for the first unit, and $25.23 for subsequent units.
- The 2023 DWC Conversion Factor is 64.83
- The 2023 Medicare Conversion Factor is 33.8872
- Using the above formula, the DWC finds the MAR is $404.25
- The respondent paid $0.00.
- Reimbursement in the amount of $404.25 is recommended.

The division finds that the requestor is entitled to reimbursement.

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 division finds the requester has established that reimbursement 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 National Union Fire Insurance Co. of Pittsb. PA must remit to Peak Integrated Healthcare $404.25 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 2, 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.