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.

MFDR Tracking Number
M4-23-2930-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
July 20, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 3, 2022	CPT Code 97750-GP (x 8) Functional Capacity Evaluation (FCE)	$502.08	$385.44
	Total	$502.08	$385.44

Requestor's Position

"7/20/23 We received NO payment or denial for this reconsideration. Please process for payment."

Amount in Dispute: $502.08

Respondent's Position

"The provider filed a DWC 60, seeking Medical Fee Dispute Resolution for a date of service of October 3, 2022. The provider billed for an FCE in the amount of $502.08. The provider attached a copy of the provider's initial medical bill as well as the carrier's EOB dated October 27, 2022. The carrier relies upon the denial codes identified on the EOB in support of its position that the provider is not entitled to any reimbursement. We are also attaching a copy of a CCH Decision and Order which found and concluded that the claimant reached MMI on November 2, 2022 with a 0% impairment rating and that the compensable injury did not extend to various… conditions that the claimant was pursuing for which, the claimant's health care providers were providing medical treatment."

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 (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.225 sets the reimbursement guidelines for FCEs.
3. 28 TAC §134.203 sets out the fee guidelines for professional services.

Denial Reasons

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

- 5721 & 112 – To avoid duplicate bill denial for all reconsiderations/adjustment.
- 119 & 90403 – Service not furnished directly to the patient and or not documented.
- 163 – The charge for this procedure exceeds the unit value and or the multiple procedure rules.

Issues

1. Did the insurance carrier raise a new issue after the filing of the medical fee dispute?
2. Is the insurance carrier's denial reason 119 and 90403 supported?
3. Is the insurance carrier's denial reason 163 supported?
4. Is the requestor entitled to reimbursement?

Findings

1. Review of the insurance carrier's response finds new denial reasons or defenses raised that were not presented to the requestor before the filing of the request for medical fee dispute resolution. Rule §133.307(d)(2)(B) requires that upon receipt of the request for medical fee dispute resolution, the respondent shall provide any missing information not provided by the requestor and known to the respondent, including: a paper copy of all initial and appeal EOBs related to the dispute, as originally submitted to the health care provider… related to the health care in dispute not submitted by the requestor or a statement certifying that the respondent did not receive the health care provider's disputed billing prior to the dispute request.

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

   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.

A review of the documentation provided by both parties, finds that the insurance carrier failed to notify the healthcare provider of specific codes or justifications for payment reductions or denials, as mandated by Rule §133.240, and Rule §133.307(d)(2)(F). 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 October 3, 2022. The insurance carrier denied/reduced the disputed service with denial reduction codes "119 and 90403 – Service not furnished directly to the patient and or not documented."

   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."

   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 both codes. 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.

CPT code 97750 is not covered on the same day as CPT codes 97161-97168 (due to CCI edits).

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

A review of the submitted documentation finds that the requestor billed for and documented a physical performance test. Because the insurance carrier's arguments for denial are unsupported, the requestor is entitled to reimbursement in accordance with 28 TAC §134.203.

3. The insurance carrier denied the disputed service with denial reduction code, "163 – The charge for this procedure exceeds the unit value and or the multiple procedure rules."

   Review of the medical bills, and EOBs for disputed CPT code 97750-GP, finds that the requestor did not bill for a functional capacity evaluation, but billed for a physical performance evaluation.

   Per 28 TAC §134.225, "The following applies to functional capacity evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a division ordered test; a maximum of two hours for an interim test; and a maximum of three hours for the discharge test unless it is the initial test."

   The DWC finds that the maximum of three FCE's shall be billed for each compensable injury. Since the requestor submitted a bill for 97750-GP, the disputed service is not subject to the requirements outlined in 28 TAC §134.225. The insurance carrier's justification for the denial is unsupported.

4. 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…"

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

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.

The MPPR Rate File that contains the payments for 2022 services is found at https://www.cms.gov/Medicare/Billing/TherapyServices/index.html.

- The date of service is October 3, 2022.
- The DWC conversion factor for 2022 is 62.46
- The Medicare conversion factor for 2022 is 34.6062.
- MPPR rates are published by carrier and locality.
- A review of Box 32 on the CMS-1500 reveals that the services were provided in zip code 75211; as a result, "Dallas" is the Medicare locality.
- The Medicare participating amount for CPT code 97750 at this locality is $34.77 for the first unit, and $25.54 for subsequent units.

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

- Using the above formula, the MAR is $62.76 for the first unit, and $46.10 for the subsequent 7 units, the total sum is therefore $385.44.
- The respondent paid $0.00. The difference between the MAR and the amount paid 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.

The DWC finds the requester has established that 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 the Respondent must remit to the Requestor, $385.44 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		November 13, 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 managing 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.