



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Peak Integrated Healthcare

**Respondent Name**

American Zurich Insurance Co.

**MFDR Tracking Number**

M4-23-2938-01

**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
5/22/2023	97750-GP	\$531.04	\$13.81
<b>Total</b>		\$531.04	\$13.81

### Requestor's Position

"We disagree that this is a duplicate or should be denied for reaching benefit maximum. This claim is a compensable injury. Please process for payment."

**Amount in Dispute:** \$531.04

### Respondent's Supplemental Position

"Our supplemental response for the above referenced medical fee dispute resolution is as follows: the bill(s) in question was/were escalated and a review completed. Our bill audit company has determined additional monies are owed in the amount of \$390.40."

**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 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 or reduced payment for the disputed services with the following claim adjustment codes:

- 112 – Service not furnished directly to patients 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.
- P12 – Workers' Compensation Jurisdictional Fee Schedule adjustment.
- 00663 – Reimbursement has been calculated according to state fee schedule guidelines.
- 592 – The recommended allowance has been proportioned based on the multiple rules for services reviewed on this date of service or partially previously reviewed on the same date of service.

### Issues

1. Has the Insurance Carrier issued payment for the reimbursement of the disputed service(s)?
2. Is the Requestor entitled to additional reimbursement for CPT Code 97750-GP?

### Findings

1. The requestor billed the insurance carrier \$531.04 for disputed service, 97750-GP x 8 units, rendered on May 22, 2023.

The insurance carrier first denied payment for the disputed service based on the reason codes mentioned above, per analysis of the submitted documentation. To support the payment made following the submission of the medical fee dispute resolution (MFDR) request, the insurance carrier submitted supplemental supporting documentation. Review of the supporting documentation finds that the insurance carrier paid the requestor \$390.44 on August 2, 2023, for the disputed service.

DWC finds that on August 2, 2023, the insurance carrier issued payment for the disputed service in the amount of \$390.44.

2. The requester is seeking additional reimbursement for 8 units of CPT code 97750-GP rendered on May 22, 2023.

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

The DWC 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.

On the disputed date of service, the requestor billed CPT code 97750-GP (x 8 units). DWC finds that the MPPR rule applies to 97750-GP.

The MPPR Rate File that contains the payments for 2023 services is found at:

[www.cms.gov/Medicare/Billing/TherapyServices/index.html](http://www.cms.gov/Medicare/Billing/TherapyServices/index.html).

To determine the MAR the following formula is used:

$(\text{DWC Conversion Factor} / \text{Medicare Conversion Factor}) \times \text{Medicare Payment} = \text{MAR}$ .

- MPPR rates are published by carrier and locality.
- The disputed date of service is May 22, 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 the subsequent 7 units.
- The 2023 DWC Conversion Factor is 64.83
- The 2023 Medicare Conversion Factor is 33.8872.
- Using the above formula, DWC finds the MAR is \$66.38 for the first unit and \$48.47 for the subsequent 7 units for a total of \$404.25.

- The insurance carrier paid \$390.44.
- The difference between the MAR and the amount paid by the insurance carrier is \$13.81.
- Additional reimbursement in the amount of \$13.81 is recommended.

DWC finds that the requestor is entitled to additional reimbursement in the amount of \$13.81.

### 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 that the requester is entitled to an additional payment in the amount of \$13.81.

### **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 American Zurich Insurance Co., must remit to Peak Integrated Healthcare, \$13.81 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

### **Authorized Signature**

		October 5, 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](http://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](mailto: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 prefieres hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).