



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Peak Integrated Healthcare

Respondent Name

Amco Insurance Company

MFDR Tracking Number

M4-25-0125-01

Carrier's Austin Representative

Box Number 06

DWC Date Received

September 17, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 23, 2024	97750-GP	\$557.52	\$0.00
Total		\$557.52	\$0.00

Requestor's Position

"... After reconsideration we were denied, payment again stating, Original payment decision is being maintained.' We disagree that this is not an allowable treatment/evaluation necessary to care for the patient's compensable injury..."

Amount in Dispute: \$557.52

Respondents' Position

"...Peak implies that a 'PPE' is not the same as an 'FCE,' this argument is disingenuous at best. Peak knew that three FCEs had been performed on this claim because on 5/22/24, Peak requested preauthorization for 8 physical performance tests (CPT 97750). The prospective request for 8 physical performance tests (CPT 97750) was non-certified. See attached Preauthorization Denial, dated 5/24/24. Carrier maintains that the denial of this bill was in compliance with DWC rules and was appropriate"

Response Submitted by: Stone Loughlin Swanson

Findings and Decision

Authority

This medical fee dispute is decided according to [Texas Labor Code \(TLC\) §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](#)) [§133.305](#) sets out the procedures for resolving medical disputes.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
3. [28 TAC §134.600](#) sets out the guidelines for Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care

Denial Reasons

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

- P12 – Workers Compensation jurisdictional fee schedule adjustment.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for consideration or appeal.
- Note: This is in response to your appeal on the attached claim. After reviewing this service date in question, we find our initial audit and recommendation appears to be correct. No additional allowance is recommended.

Issues

1. Was the physical performance test denied by utilization review?
2. Is the insurance carrier's denial reason(s) supported?
3. Is the requester entitled to reimbursement?

Findings

1. This dispute pertains to the non-payment of a physical performance test, billed under CPT code 97750 with modifier GP, conducted on July 23, 2024. The requestor seeks reimbursement in the amount of \$557.52. On behalf of the insurance carrier, Genex, URA reviewed the request for preauthorization, pursuant to 28 TAC §134.600, and denied the request for reimbursement on May 24, 2024. The disputed service is therefore reviewed pursuant to the applicable rules and guidelines.

2. The requester seeks reimbursement for CPT code 97750-GP x 8 units. The insurance carrier states, "Peak knew that three FCEs had been performed on this claim because on 5/22/24, Peak requested preauthorization for 8 physical performance tests (CPT 97750). The prospective request for 8 physical performance tests (CPT 97750) was non-certified."

A review of the medical bill and EOBs submitted with the medical fee dispute resolution request (MFDR) finds that the requestor billed for a physical performance evaluation. The requestor did not append modifier FC, which identifies that a functional capacity evaluation was performed. The DWC finds that the insurance carriers denial reasons are not supported. The disputed services are reviewed pursuant to the applicable rules and guidelines.

3. The provision of 28 TAC §134.203(b)(1) applies to the disputed service and 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 description for 97750-GP is "Physical performance test or measurement."

The requestor appended modifier GP signifies that the service was provided under a physical therapy plan of care.

The DWC finds that CPT code 97750-GP is subject to the requirements of 28 TAC §134.600(p)(5).

28 TAC §134.600 states, "(p) Non-emergency health care requiring preauthorization includes...

(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:

(A) Level I code range for Physical Medicine and Rehabilitation, but limited to:

- (i) Modalities, both supervised and constant attendance;
- (ii) Therapeutic procedures, excluding work hardening and work conditioning;
- (iii) Orthotics/Prosthetics Management;
- (iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code; and..."

A review of the submitted documentation finds that the Genex, a certified URA on behalf of the insurance carrier made an adverse determination for the prospective request for 8 physical performance test (CPT 97750). The service was rendered after the adverse determination by Genex. The URA non-certified the request for preauthorization for CPT code 97750-GP.

28 TAC §134.600 states, "(o) If the initial response is an adverse determination of preauthorization or concurrent utilization review, the requestor or injured employee may request reconsideration orally or in writing. A request for reconsideration under this section constitutes an appeal for the purposes of §19.2011 of this title (relating to Written Procedures for Appeal of Adverse Determinations).

(1) The requestor or injured employee may within 30 days of receipt of a written adverse determination request the insurance carrier to reconsider the adverse determination and shall document the reconsideration request...

(4) In any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services prior to the issuance of an adverse determination on the request for reconsideration, the insurance carrier shall comply with the requirements of §19.2010 and §19.2011 of this title, including the requirement that the insurance carrier afford the requestor a reasonable opportunity to discuss the proposed health care with a doctor or, in cases of a dental plan or chiropractic services, with a dentist or chiropractor, respectively."

"(5) The requestor or injured employee may appeal the denial of a reconsideration request regarding adverse determination by filing a dispute in accordance with Labor Code §413.031 and related division rules."

TLC 413.031 states, "(a) A party, including a health care provider, is entitled to a review of a medical service provided or for which authorization of payment is sought if a health care provider is...

(2) denied authorization for the payment for the service requested or performed if authorization is required or allowed by this subtitle or commissioner rules..."

"(d) A review of the medical necessity of a health care service requiring preauthorization under Section [413.014](#) or commissioner rules under that section or Section [413.011](#)(g) shall be conducted by an independent review organization under Chapter [4202](#), Insurance Code, in the same manner as reviews of utilization review decisions by health maintenance organizations. It is a defense for the insurance carrier if the carrier timely complies with the decision of the independent review organization."

A review of the documentation provided by the parties finds that preauthorization was required for the physical performance test. Preauthorization was sought by the requestor and denied by the insurance carrier. According to TLC 413.031 (2) (d), a determination of medical necessity is conducted by an independent review organization under Chapter 4202.

The DWC finds that the requestor sought preauthorization and was denied, as a result the medical fee dispute resolution request is not the appropriate venue for resolution of an adverse medical necessity determination. The requestor may seek resolution pursuant to 28 TAC §133.308. For the reasons indicated above, the DWC finds that the requestor is not entitled to reimbursement for CPT code 97750-GP.

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 requestor has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	February 4, 2025
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, 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 electrónico CompConnection@tdi.texas.gov.