TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
WINNSBORO CHIROPRACTIC CLINIC

Respondent Name
EAST TEXAS EDUCATIONAL INSURANCE

MFDR Tracking Number
M4-17-2445-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
April 12, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "If you continue to refuse to pay for treatment that was provided in accordance with the ODG for a diagnosis that was appropriate, when rendered in good faith after permission was obtained from the adjustor, please provide the specific verbiage from the statute."

Amount in Dispute: $1,278.75

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...we maintain the denial for all charges with the exception of Date of Service 1/4/17, would be correct. Once correct modifiers are filed to us for the OV on 12/12/16 and CPT Codes 97112 and 97140 for Date of Service 12/21/16-1/12/17, charges can be reviewed for payment. Denial for lack of preauthorization for DOS 12/12/16-12/19/16 will be maintained. Payment for CPT codes 97110, 97112 and 97140 for Date of Service 1/4/17 will be issued on 5/30/17."

Response Submitted by: Claims Administrative Services, Inc.

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
December 12, 2016 through January 12, 2017	99203, 97110, 97112, 97140, 97035, 99080, L0627 and 97010	$1,278.75	$78.75

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 28 Texas Administrative Code §129.5 sets out the procedure for Work Status Reports.
4. 28 Texas Administrative Code §134.210 sets out the reimbursement guidelines for medical documentation.
5. 28 Texas Administrative Code §134.203 sets out the professional fee guidelines.

6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure
    - 721 – Per Rule 134.600 of the Texas administrative code, this procedure requires preauthorization, preauthorization not obtained
    - 197 – Precertification/authorization/notification absent
    - 236 – This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the NCCI or workers compensation state regulations/fee schedule requirement
    - 284 – No allowance was recommended as this procedure has a Medicare status of "B" (bundled)
    - 629 – The medically unlikely edits (MUE) from CMS has been applied to this procedure code
    - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
    - 733 – Functional limitation reporting requirements have not been met G-codes including severity/complexity modifier are required
    - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication

Issue(s)

1. Is the requestor entitled to reimbursement for CPT Code 99080 rendered on December 21, 2016?
2. Is the insurance carrier denial reason(s) supported for HCPCS Code L0627?
3. Is the insurance carrier's denial reason supported for disputed CPT Code 99203?
4. Did the requestor submit documentation to support that the physical therapy services rendered December 12, 2016 through December 21, 2016 were preauthorized?
5. Did the requestor bill for the physical therapy services in accordance with 28 Texas Administrative Code §134.203 (b) and 28 Texas Administrative Code §134.600 for dates of service December 26, 2016 through January 12, 2017?
6. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 99080 rendered on December 21, 2016. The insurance carrier denied the disputed service with denial reduction codes, "97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated", and "284 – No allowance was recommended as this procedure has a Medicare status of "B" (bundled)." The Division finds the following:

    - The requestor did not append modifier -73 to CPT Code 99080 to identify that the disputed service billed was a DWC-73, pursuant to 28 Texas Administrative Code §129.5.
    - The requestor did not identify that CPT Code 99080 was for special reports or forms, outlined in 28 Texas Administrative Code §133.210.

    28 Texas Administrative Code §134.203 (b) states in pertinent part, "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."

    The AMA CPT Code Book defines CPT Code 99080 as "Special reports or forms."

    Per CMS guidelines, payment for procedure code 99080 is always bundled into payment for other services not specified and no separate payment is made. As a result, the requestor is not entitled to reimbursement for CPT Code 99080 rendered in December 21, 2016.

2. The requestor seeks reimbursement for HCPCS Code L0627 rendered on December 29, 2016. The insurance carrier denied the disputed service with denial reduction codes, "629 – The medically unlikely edits (MUE) from CMS has been applied to this procedure code", and "97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." Review of the submitted documentation finds that the insurance carrier denial reasons "629" and "97" are not supported.

    28 Texas Administrative Code §134.203 (b) states in pertinent part, "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."

The AMA CPT Code Book defines HCPCS Code L0627 as "Lumbar orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise."

The insurance carrier states, "...Dr. Perish is not a durable medical equipment supplier. Our records indicate a provider must be formally enrolled as a DME supplier in order to be reimbursed for certain DME. HCPCS code L0627 is one of those codes."

28 Texas Administrative Code §133.307(d)(2)(F) states "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."

The respondent submitted a position summary containing new denial reasons. The additional denial reasons identified on the position summary, are not denial reasons raised during the medical bill review process, as they are not indicated on the Explanation of Benefits presented with the DWC060. The respondent submitted insufficient information to MFDR to support that the submitted denial reasons raised in their position summary were presented to the requestor or that the requestor had otherwise been informed of these new denial reasons or defenses prior to the date that the request for medical fee dispute resolution was filed with the Division; therefore, the Division concludes that the respondent has waived the right to raise such additional denial reasons or defenses. Any newly raised denial reasons or defenses shall not be considered in this review. The division finds that the requestor is entitled to reimbursement for HCPCS Code L0627.

28 Texas Administrative Code §134.203 states in pertinent part, "(d) The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule..."

28 Texas Administrative Code §134.203 states in pertinent part, "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount..."

DME Code L0627 rendered on December 29, 2016, represents a supply or equipment with reimbursement determined per §134.203(d). The fee listed for this code in the Medicare DMEPOS fee schedule is $393.97 x 125% of this amount is $492.46. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $60.00. Therefore, this amount is recommended.

3. The requestor seeks reimbursement for CPT Code 99203 rendered on December 12, 2016. The insurance carrier denied the disputed service with denial reduction code, "435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure" and "236 – This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the NCCI or workers compensation state regulations/fee schedule requirement."

   28 Texas Administrative Code §134.203 (b) states in pertinent part, "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."

   Review of the CMS 1500's documents that the requestor billed the following CPT Codes on December 12, 2016; 99203, 98940, 97110, 97112 and 97140.

   The Division completed NCCI edits to identify potential edit conflicts that may affect reimbursement. The following was identified for CPT Code 99203 rendered on December 12, 2016.

   Per CCI Guidelines, Procedure Code 99203[OFFICE OUTPATIENT NEW 30 MINUTES] has a CCI conflict with Procedure Code 98940[CHIROPRACTIC MANIPULATIVE TX SPINAL 1-2 REGIONS5]. Per CMS CCI guidelines, a modifier is ALLOWED to override the CCI conflict.

   Review of the CMS-1500 identifies CPT Code 99203 without a modifier. As a result, due to the CCI conflict reimbursement cannot be recommended for this service. The requestor is therefore entitled to $0.00 for CPT Code 99203 rendered on December 12, 2016.

4. The requestor seeks reimbursement for CPT Codes 97110, 97112, 97140 and 97035 rendered on December 12, 2016, December 14, 2016, December 15, 2016, December 19, 2016 and December 21, 2016. The disputed services were denied by the insurance carrier with denial reduction code; "197 – Precertification/authorization/notification absent."

   Per 28 Texas Administrative Code §134.600 states in relevant part, "(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... (C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following... (i) the date of injury..."

   Review of the submitted documentation finds that the requestor submitted insufficient documentation to support that preauthorization was obtained for the disputed services rendered on December 12, 2016 through December 21, 2016. As a result, reimbursement for CPT Codes 97110, 97112, 97140 and 97035 rendered on December 12, 2016, December 14, 2016, December 15, 2016, December 19, 2016 and December 21, 2016 is not recommended.

   - The insurance carrier denied the following services with denial reduction codes:
   - 435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure
   - 236 – This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the NCCI or workers compensation state regulations/fee schedule requirement
   - 284 – No allowance was recommended as this procedure has a Medicare status of "B" (bundled)
   - 629 – The medically unlikely edits (MUE) from CMS has been applied to this procedure code
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 733 – Functional limitation reporting requirements have not been met G-codes including severity/complexity modifier are require
   - 721 – Per Rule 134.600 of the Texas administrative code, this procedure requires preauthorization, preauthorization not obtained
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
   - 197 – Precertification/authorization/notification absent

Date of service in dispute	CPT Code	Ordered Amount
December 26, 2016	97112 and 97140,	$0.00
December 29, 2016	97112 and 97140	$0.00
January 2, 2017	97112 and 97140	$0.00
January 4, 2017	97110, 97112, 97140 and 97010	$18.75
January 9, 2017	97112, 97140 and 97010	$0.00
January 12, 2017	97112, 97140 and 97010	$0.00

   Per 28 Texas Administrative Code §134.600 states in relevant part, "(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... (C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following... (i) the date of injury..."

   Review of the preauthorization letter dated December 22, 2016 issued by RM Review Med, states the following, "Based on the submitted records, the peer to peer discussion and noting that 5 treatment sessions have already been completed, Dr. Perish agreed to a negotiated treatment plan of CMT, code 98940, and PT, codes 97112, 97110, 97140, not to exceed a combined total of 4 units per sessions x 7 sessions over 3 weeks."

   The division finds that the disputed CPT Codes, 97112, 97110 and 97140 were rendered within the preauthorized timeframe. As a result, the insurance carrier's denial reasons, "197", and "721" are not supported. The Division will therefore review the disputed physical therapy services pursuant to 28 Texas Administrative Code §134.203 (b).

   28 Texas Administrative Code §134.203 (b) states in pertinent part, "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."

The Division completed NCCI edits to identify potential edit conflicts that may affect reimbursement. The Division reviewed the CMS-1500's and completed NCCI edits to identify potential edit conflicts that may affect reimbursement. The following was identified:

Review of the CMS-1500's documents that the requestor billed CPT Codes 98940, 97110, 97112, and 97140 on: December 26, 2016; December 29, 2016 and January 2, 2017:

- Per CCI Guidelines, Procedure Code 97112 (Therapy PX 1/> Areas Each 15 Min Neuromuscular Reeducation) has a CCI conflict with Procedure Code 98940 (Chiropractic Manipulative TX Spinal 1-2 Regions4). Per CMS CCI guidelines, a modifier is ALLOWED to override the CCI conflict.
- Per CCI Guidelines, Procedure Code 97140 (Manual Therapy TQS 1/> Regions Each 15 Minutes) has a CCI conflict with Procedure Code 98940 (Chiropractic Manipulative TX Spinal 1-2 Regions4). Per CMS CCI guidelines, a modifier is ALLOWED to override the CCI conflict

The Division finds that the requestor did not append a modifier to override the CCI conflicts, therefore reimbursement cannot be recommended for CPT Codes 97112 and 97140 rendered on December 26, 2016 through January 2, 2017.

Review of the CMS-1500's documents that the requestor billed CPT Codes 98940, 97110, 97112, 97140 and 97010 on January 4, 2017; January 9, 2017 and January 12, 2017:

- Per CCI Guidelines, Procedure Code 97112 (Therapy PX 1/> Areas Each 15 Min Neuromuscular Reeducation) has a CCI conflict with Procedure Code 98940 (Chiropractic Manipulative TX Spinal 1-2 Regions4). Per CMS CCI guidelines, a modifier is ALLOWED to override the CCI conflict
- Per CCI Guidelines, Procedure Code 97140 (Manual Therapy TQS 1/> Regions Each 15 Minutes) has a CCI conflict with Procedure Code 98940 (Chiropractic Manipulative TX Spinal 1-2 Regions4). Per CMS CCI guidelines, a modifier is ALLOWED to override the CCI conflict

The Division finds that the requestor did not append a modifier to CPT Code 97112 and 97140 to override the CCI conflicts, as a result, reimbursement cannot be recommended for CPT Codes 97112 and 97140 rendered on January 4, 2017 through January 12, 2017.

The requestor seeks reimbursement for CPT Code 97010 rendered on January 4, 2017; January 9, 2017 and January 12, 2017. Publication 100-04 Medicare Claims Processing manual states in pertinent part, "Codes 97010 *are* bundled. *They are* bundled with any therapy codes. Regardless of whether *they are* billed alone or in conjunction with another therapy code, never make payment separately for th*ese codes*. If billed alone, *either code* should be denied using the existing EOMB/MSN language. For remittance advice notices, use group code CO and claim adjustment reason code 97 that says: "Payment is included in the allowance for another service/procedure."

The Division finds that CPT Code 97010 is always bundled and therefore separate reimbursement for this code is not warranted. As a result, $0.00 is recommended for CPT Code 97010 rendered on January 4, 2017; January 9, 2017 and January 12, 2017.

The requestor is however, entitled to reimbursement for CPT Codes 97110 for date of service January 4, 2017.

CMS Chapter 10.7 - Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services states, "Medicare applies a multiple procedure payment reduction (MPPR) to the practice expense (PE) payment of select therapy services. The reduction applies to the HCPCS codes contained on the list of "always therapy" services (see section 20), excluding A/B MAC (B)-priced, bundled and add-on codes, regardless of the type of provider or supplier that furnishes the services.

Medicare applies an MPPR to the PE payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The MPPR applies to all therapy services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, for example, physical therapy, occupational therapy, or speech-language pathology. Full payment is made for the unit or procedure with the highest PE payment."

As a result, reimbursement is calculated pursuant to 28 Texas Administrative Code 134.203 (c) for CPT Code 97110 rendered on January 4, 2017.

5. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) 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. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..." The calculation of the Maximum Allowable Reimbursement (MAR) is found below:

Date of Service	CPT Code	Units	Submitted Charges	MAR	Paid Amount	Amount Due
January 4, 2017	97110	1	$18.75	$50.84	$0.00	$18.75
TOTAL		1	$18.75	$50.84	$0.00	$18.75

Procedure code 97110, with service date January 4, 2017 is a professional service paid per Rule §134.203 (c). For this code, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.45. The practice expense (PE) RVU of 0.45 multiplied by the PE GPCI of 0.929 is 0.41805. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.809 is 0.01618. The sum of 0.88423 is multiplied by the division conversion factor of $57.50 for a MAR of $50.84. Per Medicare policy, when more than one unit of designated therapy services is billed, full payment is made for the first unit of the code with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This code has the highest PE for this date. The first unit is paid at $50.84. Per Rule §134.203 (h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $18.75; therefore, this amount is recommended for January 4, 2017.

Review of the submitted documentation finds that. The requestor is entitled to a total recommended reimbursement amount of $78.75. As a result, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $78.75.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $78.75 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 9, 2019 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 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 the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division 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 with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

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