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
HEALTH PLUS CHIROPRACTIC

Respondent Name
SENTRY CASUALTY COMPANY

MFDR Tracking Number
M4-21-0139-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 28, 2020

Response Submitted By:
Flahive, Ogden & Latson

REQUESTOR'S POSITION SUMMARY

"We've billed for DOS of 2020-06-27 and has received payment. We didn't know that we have to get pre-approval for additional treatments since we already got approval for changing of treating doctor."

RESPONDENT'S POSITION SUMMARY

"The provider is not entitled to reimbursement for any of the dates of service. Those services are for physical therapy which requires preauthorization pursuant to Division rule 134.600 (p)(5). Even the provider has acknowledged that it failed to request preauthorization which is the basis of the carrier's EOB denials. Since physical therapy requires preauthorization and since preauthorization was not requested, much less approved, the provider is not entitled to any reimbursement for the physical therapy services."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 25, 2020 through August 21, 2020	97813, 97012, 97110, 98941, 98940, 99213 and G0283	$3,157.00	$1,741.36

FINDINGS AND DECISION

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

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2012 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
3. 28 TAC §134.600, effective November 1, 2018, set outs the preauthorization requirements.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - A90 – THIS CHARGE WAS REIMBURSED IN .ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE
   - 240 – PREAUTHORIZATION NOT OBTAINED
   - 197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT
   - 612 – NO PAYMENT IS MADE AS MEDICARE USES ANOTHER CODE FOR REPORTING AND/OR PAYMENT OF THIS SERVICE WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - P12 – WORKERS COMPENSTATION JURISDICITON FEE SCHEDULE ADJUSTMENT
   - P2 – THE APPLICABLE FEE SCHEDULE/FEE DATABASE DOES NOT CONTAIN THE BILLED BODE. PLEASE RESUMIT A BILL WITH THE APPROPRIATE FEE SCHEDULE/FEE DATATBASE CODE(S) THAT BEST DESCRIBE THE SERVICE(S) PROVIDED AND SUPPORTING DOCUMENATION IF REQUIRED
   - M49 – MISSING/INCOMPLETE/INVALID CODE(S) OR AMOUNT(S)

Issues

1. What are the insurance carrier's denial reason(s) for non-payment?
2. What is the definition of the disputed CPT/HCPCS codes?
3. Did the requestor obtain preauthorization for the disputed services?
4. What rules apply to the reimbursement of the disputed services?
5. Is the requestor entitled to reimbursement for the services in dispute?

Findings

1. The requestor seeks reimbursement in the amount of $3,157.00 for physical therapy codes rendered on July 25, 2020 through August 21, 2020.

   The respondent denied reimbursement for the disputed physical therapy services based upon reason codes 197- Payment denied/reduced for exceeded precertification/authorization and 240-Preauthorization not obtained.

   The requestor states, "We didn't know that we have to get pre-approval for additional treatments since we already got approval for changing of treating doctor."

   The DWC will determine if the CPT Codes in dispute require preauthorization pursuant to 28 TAC §134.600 (p)(5).

2. The fee guidelines for services in dispute are found at 28 TAC §134.203.

   28 TAC §134.203(b)(1) states, "(b) 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 disputed services are described as:
   - CPT Code 97110 – "Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility."
   - CPT Code 97813 – "Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient."
   - CPT Code 97012 – "Application of a modality to 1 or more areas; traction, mechanical."
   - CPT Code 98941 – "Chiropractic manipulative treatment (CMT); spinal, 3-4 regions."
   - CPT Code 98940 – "Chiropractic manipulative treatment (CMT); spinal, 1-2 regions."
   - CPT Code 99213 – "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, **15** minutes are spent face-to-face with the patient and/or family."

- CPT Code G0283 – “Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care.”

The Medicare Claims Processing Manual, Chapter 5, Subsection C. Additional HCPCS Codes, states in pertinent part, “The PT or OT would use the appropriate HCPCS/CPT code(s) in the 97000 - 97799 series and the corresponding therapy modifier, GP or GO, must be used.”

3. To determine if the disputed services are eligible for reimbursement the DWC refers to the following:

   - 28 TAC §134.600 (p) states,

     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.

   The DWC finds physical therapy services require preauthorization per 28 TAC §134.600.

   - 28 TAC §134.600 (f) states,

     The requestor or injured employee shall request and obtain preauthorization from the insurance carrier prior to providing or receiving health care listed in subsection (p) of this section. Concurrent utilization review shall be requested prior to the conclusion of the specific number of treatments or period of time preauthorized and approval must be obtained prior to extending the health care listed in subsection (q) of this section. The request for preauthorization or concurrent utilization review shall be sent to the insurance carrier by telephone, facsimile, or electronic transmission and, include the:

     (2) specific health care listed in subsection (p) or (q) of this section;

     (3) number of specific health care treatments and the specific period of time requested to complete the treatments.

   The DWC finds that HCPCS/CPT codes G0283, 97012 and 97110 were subject to preauthorization. Review of the submitted documentation does not support that preauthorization was obtained, as a result, reimbursement cannot be recommended.

   The DWC finds that CPT Codes, 97813, 98941, 98940, and 99213 are not considered physical therapy codes and therefore, not subject to the preauthorization requirements set out in 28 TAC 134.600 (p)(5). These codes are reviewed pursuant to the applicable rules and guidelines.

4. Per 28 TAC §134.203(c)(1)(2), “To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. 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. 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 following hypothetical example illustrates this annual adjustment activity if the DWC had been using this MEI annual percentage adjustment: The 2006 DWC conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) DWC conversion factor in 2007.”

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

   - The 2020 DWC Conversion Factor is 60.32
   - The 2020 Medicare Conversion Factor is 36.0896
   - The services were provided in Angleton, TX, Rest of Texas

Date	Code	Units	Amount Billed	MAR	Insurance Carrier Paid	Amount Due
7/25/2020	98940-AT	1	$50.00	$49.32	$0.00	$49.32
7/27/2020	99213-25	1	$49.00	$129.68	$0.00	$49.00
	98941-AT	1	$65.00	$70.95	$0.00	$65.00
	97813-GP	1	$79.00	$71.92	$0.00	$71.92
7/29/2020	98941-AT	1	$65.00	$70.95	$0.00	$65.00
	97813-GP	1	$79.00	$71.92	$0.00	$71.92
7/31/2020	98941-AT	1	$65.00	$70.95	$0.00	$65.00
	97813-GP	1	$79.00	$71.92	$0.00	$71.92
8/4/2020	98941-AT	1	$65.00	$70.95	$0.00	$65.00
	97813-GP	1	$79.00	$71.92	$0.00	$71.92
8/5/2020	98941-AT	1	$65.00	$70.95	$0.00	$65.00
	97813-GP	1	$79.00	$71.92	$0.00	$71.92
8/7/2020	98941-AT	1	$65.00	$70.95	$0.00	$65.00
	97813-GP	1	$79.00	$71.92	$0.00	$71.92
8/10/2020	98941-AT	1	$65.00	$70.95	$0.00	$65.00
	97813-GP	1	$79.00	$71.92	$0.00	$71.92
8/12/2020	98941-AT	1	$65.00	$70.95	$0.00	$65.00
	97813-GP	1	$79.00	$71.92	$0.00	$71.92
8/14/2020	98941-AT	1	$65.00	$70.95	$0.00	$65.00
	97813-GP	1	$79.00	$71.92	$0.00	$71.92
8/17/2020	98941-AT	1	$65.00	$70.95	$0.00	$65.00
	97813-GP	1	$79.00	$71.92	$0.00	$71.92
8/19/2020	98941-AT	1	$65.00	$70.95	$0.00	$65.00
	97813-GP	1	$79.00	$71.92	$0.00	$71.92
8/21/2020	98941-AT	1	$65.00	$70.95	$0.00	$65.00
	97813-GP	1	$79.00	$71.92	$0.00	$71.92
TOTAL			$1,827.00	$1,893.44	$0.00	$1,741.36

5. The DWC finds that the requestor is entitled to reimbursement in the amount of $1,741.36. Therefore, this amount is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,741.36.

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 DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of $1,741.36 plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 12, 2020 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 TAC §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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed, or personally delivered to the DWC 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 DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

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