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
ELITE HEALTHCARE NORTH DALLAS

Respondent Name
HANOVER AMERICAN INSURANCE CO

MFDR Tracking Number
M4-21-0879-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
JANUARY 29, 2021

REQUESTOR'S POSITION SUMMARY

"The attached dates of service were not paid in full. These services were originally reduced due as 'the usual treatment session provided in the home or office setting is 30 to 45 minutes. The medical necessity of services for an unusual length of time must be documented.' Which is **INCORRECT**! The claims in question were resubmitted as a reconsideration request and the carrier deemed that more was due. The issue being – the second checks issued still do not pay for the service in full and more so, do not include a specific reason as to why the services have been reduced, yet again."

Amount in Dispute: $1,005.88

RESPONDENT'S POSITION SUMMARY

"The allowance for CPT code 97112, billed with two (2) units, is $107.29…The allowance for CPT code 97110 is based on allowing two (2) units at $40.73 (totaling $81.46)….the remaining four (4) units require pre-authorization approval, therefore our recommendation is based on allowing two (2) units. "

Response Submitted By: Medata Service Operations

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 18, 2020 August 20, 2020 August 27, 2020 September 1, 2020	CPT Code 97110-GP (X6)	$236.72/ea date	$651.72
	CPT Code 97112-GP (X2)	$14.75/ea date	$0.00
TOTAL		$1,005.88	$651.72

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 (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, requires preauthorization for specific treatments and services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - P12-The charge for the procedure exceeds the amount indicated in the fee schedule.
   - MZ-The usual treatment session provided in the home or office setting is 30 to 45 minutes. The medical necessity of services for an unusual length of time must be documented.
   - @F-The benefit for this service is included in the payment/allowance for another service/procedure that has been performed on the same day.
   - W3-Additional payment made on appeal/reconsideration.

Issues

Is the requestor entitled to additional reimbursement for physical therapy services rendered on August 18, 2020 through September 1, 2020?

Findings

1. Elite Healthcare North Dallas billed for physical therapy services, CPT codes 97110-GP and 97112-GP rendered on August 18, 2020 through September 1, 2020. The requestor contends that the reimbursement was not in accordance with the fee guideline and additional reimbursement of $1,005.88 is due.
2. The fee guidelines for disputed services is found at 28 TAC §134.203.

   28 TAC §134.203(a)(5) states, "'Medicare payment policies' when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   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 97112 –"Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities."

   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."
3. According to the explanation of benefits, the respondent paid $81.46 for CPT code 97110-GP based upon "MZ-The usual treatment session provided in the home or office setting is 30 to 45 minutes. The medical necessity of services for an unusual length of time must be documented."

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

   - 28 TAC §134.203(a)(7) states,

     > Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program. Independent Review Organization (IRO) decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review Organizations), which are made on a

case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies.

- 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 rule 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 requestor wrote that payment is due because the disputed services were preauthorized. In support of their position, the requestor submitted a copy of a report from Claims Eval dated July 31, 2020 authorizing "9 visit over 8 weeks". The DWC finds the preauthorization report is not in accordance with rule 134.600, because it does not list the "number of specific health care treatments and the specific period of time requested to complete the treatments."

The DWC finds the reports also refer to a Medicare payment policy regarding Medically Unlikely Edit (MUE). MUE's were implemented by Medicare in 2007. MUE's set a maximum number of units for a specific service that a provider would report under most circumstances for a single patient on a single date of service. Medicare developed MUE edits to detect potentially medically unnecessary services.

Although the DWC adopts Medicare payment policies by reference in applicable Rule §134.203, paragraph (a)(7) of that rule states that specific provisions contained in the Division of Workers' Compensation rules shall take precedence over any conflicting provision adopted the Medicare program.

The Medicare MUE payment policy is in direct conflict with Texas Labor Code §413.014 which requires that all determinations of medical necessity shall be made prospectively or retrospective through utilization review; and with Rule §134.600 which sets out the procedures for preauthorization and retrospective review of professional services such as those in dispute here. The DWC concludes that Labor Code §413.014 and 28 TAC §134.600 take precedence over Medicare MUE's; therefore, the respondent's denial reasons are not supported.

4. 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.

Review of the Medicare policies finds that the multiple procedure payment reduction (MPPR) applies to the Practice Expense (PE) of certain time-based physical therapy codes when more than one unit or procedure is provided to the same patient on the same day. Medicare publishes a list of the codes subject to MPPR annually.

For 2020 the codes subject to MPPR are found in CMS *CY 2020 PFS Final Rule Multiple Procedure Payment Reduction Files.* Review of that list find that code 97110 and 97112 are subject to MPPR policy.

Here is a chart ranking the PE payment for each of the codes billed by the health care provider on the disputed dates.

CODE	PRACTICE EXPENSE	MEDICARE POLICY
97110	0.4	MPPR applies
97112	**0.48**	**Highest rank, no MPPR**

As shown above, code 97112 has the highest PE payment among the services billed by the provider that day, therefore, the reduced PE payment applies to all other services.

The *MPPR Rate File* that contains the payments for 2020 services is found at https://www.cms.gov/Medicare/Billing/TherapyServices/index.html.

- MPPR rates are published by carrier and locality.
- The services were provided in Carrollton, TX.
- The carrier code for Texas is 4412 and the locality code for Carrollton is 11.

CODE	INITIAL UNIT PAYMENT	MPPR PAYMENT
97110	$24.37	$24.37
97112	$36.51	$27.68

6. Per 28 Texas Administrative Code §134.203(c)(1)(2), "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 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

Using the above formula, the DWC finds the MAR is:

Dates	Code	Units	Medicare Payment	MAR or §134.203 (h) Lesser of MAR billed amount	Insurance Carrier Paid	Amount Due
August 18, 2020 August 20, 2020 August 27, 2020 September 1, 2020	97110	6	$24.37	$40.73 x 6 = $244.39	$81.46 per date	$162.93 x 4 dates = $651.72
	97112	1	$36.51	$36.51 x 1 = $61.02	$107.29 per date	$0.00
	97112	1	$27.68	$27.68 x 1 = $46.26		
					Total Allowable Reimbursement	$651.72

The requestor is due the difference between the total allowable and paid of $651.72.

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 $651.72.

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 $651.72 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	03/04/2021 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 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 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.