TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ANGLETON REHABILITATION AND WELLNESS

MFDR Tracking Number
M4-21-0972-01

MFDR Date Received
February 22, 2021

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative
Box Number 45

Response Submitted By:
SORM

REQUESTOR'S POSITION SUMMARY

"The purpose of this letter is letter is to file a dispute on the above-mentioned claim that denied 1 unit of 97110 and/or 1 unit of 97530 for exceeding authorization. Following is the EOR, original claim, and a copy of the authorization #... which approved 97530, 97112, and 97110 with no limitations; therefore, the services were performed based on the medical necessity."

RESPONDENT'S POSITION SUMMARY

"Likewise, in the current instance medical necessity was not established for units over the 1 hour that was certified by our Utilization review agent. SORM respectfully requests the Division find that the disputed services should have been either limited to what was approved in the preauthorization or submitted by the requestor to an Independent Review Organization pursuant to Rule §133.308. Medical necessity has not been established for units exceeding the 4 units (1 hour) per ODG and Medicare's policies."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 16, 2020 through September 28, 2020	97110 and 97530	$930.00	$389.73

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, requires preauthorization for specific treatments and services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 198-Payment denied/reduced for exceeded precertification/authorization.
   - 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
   - W3-Additional payment made on appeal/reconsideration.
   - Note: Recommended payment for 4 units only per preauth

Issues

1. What are the insurance carrier's denial reason(s) for non-payment?
2. Did the requestor obtain preauthorization for the disputed services?
3. What rules apply to the reimbursement of the disputed services?
4. What are the CMS payment policies for physical therapy services?
5. Is the requestor entitled to additional reimbursement for physical therapy services rendered September 16, 2020 through September 28, 2020?

Findings

1. The requestor seeks reimbursement in the amount of $930.00 for CPT Codes 97110 and 97530 rendered on September 16, 2020 through September 28, 2020.

   The respondent denied reimbursement for the disputed physical therapy services based upon reason code. "198- Payment denied/reduced for exceeded precertification/authorization."

   The requestor contends that preauthorization was obtained; therefore, reimbursement is due. The requestor submitted a copy of the utilization review letter dated September 15, 2020. The report indicates the following:

   - September 15, 2020, Care Works authorized 12 sessions of physical therapy services (97110, 97112, 97530, 95831, 95832 and 95851).
   - Services approved from 9/14/2020 through 11/30/2020.
   - Review of beginning of page 2 of the report states, "Per CMS Guidelines, treatment past 45-60 minutes requires documentation substantiating the medical necessity of the additional time. If more than one unit of any modality is utilized, there must be documentation to support the medical necessity…"

2. 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 the preauthorization reports are not in accordance with Rule §134.600, because they do 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.

3. 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 97530 – "Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes."
   - The requestor appended the "GP" modifier to the codes. The "GP" modifier is described as "Services delivered under an outpatient physical therapy plan of care."

4. Per 28 TAC §134.203(a)(7), "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."

   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 1615-F the CY *2020 PFS Final Rule Multiple Procedure Payment Reduction Files.*

Review of that list find that code 97110, and 97530 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
97530	0.66	Highest rank, no MPPR for first unit
97110	0.40	MPPR applies

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 Angleton, TX.
- The carrier code for Texas is 4412 and the locality code for Brazoria is 09.

CODE	MPFS	MPFS MPPR		DWC MAR	DWC MPPR MAR
97110	$31.74	$24.45		$53.05	$40.87
97530	$40.85	$28.82		$68.28	$48.17

5. 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 following Table reflects the insurance carrier's payment for physical therapy services, application of MMPR, and findings. Using the above formula, the DWC finds the MAR is:

Date	Code	Units	MAR	Insurance Carrier Paid	Amount Due
9/16/20	97530	1	$68.28	$212.80 (4 UNITS)	$48.17
	97530	4	$48.17 X 4 = $192.68 $68.28 + $192.68 = MAR $260.96		
	97110	1	$40.87	$0.00	$40.87
9/17/20	97530	1	$68.28	$212.80 (4 UNITS)	$48.17
	97530	4	$48.17 X 4 = $192.68 $68.28 + $192.68 = MAR $260.96		
	97110	1	$40.87	$0.00	$40.87
9/21/20	97530	1	$68.28	$212.80 (4 UNITS)	$48.17
	97530	4	$48.17 X 4 = $192.68 $68.28 + $192.68 = MAR $260.97		
	97110	1	$40.87	$0.00	$40.87
9/23/20	97530	1	$68.28	$212.80 (4 UNITS)	$0.00
	97530	3	$48.17 X 3 = $144.51 $68.28 + $144.51 = MAR $212.80		
	97110	1	$40.87	$0.00	$40.87
9/24/20	97530	1	$68.28	$212.80 (4 UNITS)	$0.00
	97530	3	$48.17 X 3 = $144.51 $68.28 + $144.51 = MAR $212.80		
	97110	1	$40.87	$0.00	$40.87
9/28/20	97530	1	$68.28	$164.63 (3 UNITS)	$0.00
	97530	2	$48.17 X 2 = $96.34 $96.34 + $68.28 = MAR $164.62		
	97110	2	$40.87 x 2 = $81.74	$40.87	$40.87
TOTAL				$1,269.50	$389.73

The total allowable for the disputed physical therapy services per the DWC fee guideline is $389.73. 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 $389.73.

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 $389.73 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	March 24, 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 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.