Division of Workers' Compensation

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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
James A. Mitchell, DC

Respondent Name
Republic Franklin Insurance Co.

MFDR Tracking Number
M4-22-0132-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
September 22, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 8, 2021 May 10, 2021	CPT Code 99213	$163.14/ea	$326.28
	CPT Code 99080	$15.00/ea	$30.00
February 11, 2021 February 24, 2021 February 26, 2021 March 1, 2021 March 5, 2021	CPT Code 97110 (X6)	$323.52/ea	$1,241.15
	CPT Code 97112 (X2)	$125.42/ea	$550.20
	Total	$2,600.98	$2,147.63

Requestor's Position

"Medical provider not authorized/certified to provide treatment to injured workers.' This is incorrect. This provider is an authorized treater in workers' compensation. Dr. Mitchell was approved as the patient's new treating doctor in Nov 2020 and authorization for the physical therapy was given to Elite Healthcare on Feb 5, 2021."

Amount in Dispute: $2,600.98

Respondent's Position

The Austin carrier representative for Republic Franklin Insurance Co is J T Parker & Associates LLC. J T Parker & Associates LLC received a copy of this medical fee dispute on September 28, 2021. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information

As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.239 sets out medical fee guidelines for workers' compensation specific services.
3. 28 TAC §129.5 sets out the procedure for reporting and billing work status reports.
4. 28 TAC §134.203 sets out the fee guidelines for professional services.

Denial Reasons

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

- P16-Medical provider not authorized/certified to provide treatment to injured worker in this jurisdiction.
- 45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual).
- 18-Exact duplicate claim/service.

Issues

1. Is Republic Franklin Insurance Company's denial based on reason code 45 supported?
2. Is Republic Franklin Insurance Company's denial based on reason code P16 supported?
3. Is Dr. James Mitchell entitled to reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $2,600.98 for CPT codes 99080, 99213, 97110, 97112 rendered from February 8 through May 10, 2021.

   According to the explanation of benefits, the carrier reduced payment for the disputed services based upon "45- Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual)." A review of the submitted documentation finds that neither party to the dispute submitted a copy of the contractual agreement; therefore, the respondent's denial based upon reason code 45 is not supported.

2. The respondent also denied reimbursement for the disputed services based upon reason code "P16-Medical provider not authorized/certified to provide treatment to injured worker in this jurisdiction."

   On November 17, 2020, the DWC approved the claimant's request to change treating doctor to Dr. James Mitchell.

   On February 5, 2021, the respondent's representative, Genex, gave preauthorization approval for six (6) sessions of physical therapy.

   The respondent did not submit any documentation to support the P16 denial reason. The DWC finds based upon the DWC's approval to change doctors and Genex's preauthorization approval, the requestor is due reimbursement.

3. The fee guideline for CPT codes 99213, 97110 and 97112 is found at 28 TAC §134.203.

   28 TAC §134.203(c)(1) states "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."

   28 Texas Administrative Code §134.203(c)(2) states "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 Division had been using this MEI annual percentage adjustment: The 2006 Division 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) Division conversion factor in 2007."

   A. CPT code 99213

   CPT code 99213 is described as, "Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or

examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter."

The requestor billed for two (2) office visits on the disputed dates of service.

- Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 75211 which is located in Dallas, Texas; therefore, the Medicare locality is "Dallas, Texas."
- The Medicare participating amount for CPT code 99213 at this locality is $93.06
- The DWC conversion factor for 2021 is 61.17

The Medicare conversion factor for 2021 is 34.8931.

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

Using the above formula, the MAR is $163.14. The requestor billed for two units; therefore, $163.14 X 2 = $326.28. The respondent paid $0.00. The requestor is due the difference between MAR and amount paid of $326.28.

B. CPT codes 97110 and 97112

- 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."

On the disputed dates of service, the requestor billed CPT codes 97110 (X6) and 97112 (X2). The multiple procedure rule discounting applies to the disputed service.

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.

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	**0.49**	**Highest rank, no MPPR for first unit**

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 2021 services is found at https://www.cms.gov/Medicare/Billing/TherapyServices/index.html.

- MPPR rates are published by carrier and locality.
- The carrier code for Texas is 4412 and the locality code for Dallas is 11.
- The DWC conversion factor for 2021 is 61.17
- The Medicare conversion factor for 2021 is 34.8931.

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

Using the above formula, the MAR is:

Code	Units	Medicare Payment	MAR or §134.203 (h) Lesser of MAR billed amount	Insurance Carrier Paid	Amount Due
97110	6	$23.60*	$41.37 x 6 = $248.23	$0.00	$248.23 X 5 dates = $1,241.15

97112	1	$27.00*	$47.33	$0.00	$47.33 X 5 dates = $236.65
97112	1	$35.77	$62.71	$0.00	$62.71 X 5 dates = $313.55
		*MPPR reduced payment		Total Allowable Reimbursement	$1,791. 35

d. CPT code 99080-73

CPT code 99080-73 is described as "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form."

28 TAC §134.239 states, "When billing for a work status report that is not conducted as a part of the examinations outlined in §134.240 and §134.250 of this title, refer to §129.5 of this title."

28 TAC §129.5(i)(1) states "Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15. A doctor shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section."

28 TAC §129.5 (d)(1) and (2) states "The doctor shall file the Work Status Report:
(1) after the initial examination of the employee, regardless of the employee's work status;

(2) when the employee experiences a change in work status or a substantial change in activity restrictions."

The requestor billed for two (2) work status reports on the disputed dates of service; therefore, two (2) X $15.00 = $30.00.

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.

DWC finds the requester has established that additional reimbursement of $2,147.63 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Republic Franklin Insurance Co. must remit to Dr. James Mitchell $2,147.63 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	01/07/2022 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, please 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 electronico CompConnection@tdi.texas.gov.