TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
James A. Mitchell, DC

Respondent Name
Indemnity Insurance Co. of North America

MFDR Tracking Number
M4-22-0254-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
October 7, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 16, 2020 June 15, 2021	CPT Code 97110-GP	$0.00	$0.00
December 16, 2020	CPT Code 97112-GP	$0.00	$0.00
December 16, 2020 May 19, 2021	CPT Code 99080-73	$0.00	$0.00
December 16, 2020	CPT Code 99214	$185.68	$0.00
March 15, 2021	CPT Code 99080-73	$15.00	$15.00
March 15, 2021	CPT Code 99213	$0.00	$0.00
May 19, 2021	CPT Code 99213	$163.14	$163.14
June 15, 2021	CPT Code 97112-GP	$70.40	$165.06
June 17, 2020	CPT Code 97112-GP	$110.04	
June 17, 2020	CPT Code 97110-GP	$248.22	$248.22
	Total	$792.48	$591.42

Requestor's Position

"All necessary and supporting documentation is included with this reconsideration to properly justify/support the administered treatment still needing to be paid."

Email dated January 18, 2022: "Please proceed with the dispute, I have not received any payment."

Amount in Dispute: $792.48

Respondent's Position

"We will provided a supplemental response once the bill auditing company has finalized their review."

The respondent submitted copies of bills, EOBs, and medical records that support the following payments were made.

Date	Code (s)	Amount Paid	Check No.
December 16, 2020	97110-GP, 97112-GP, 99080	$366.66	0168417025
March 15, 2021	99213	$163.14	0170155412
May 19, 2021	99080-73	$15.00	0171665338
June 15, 2021	97110-GP, 97112-GP	$303.24	0172416506

Response Submitted By: Gallagher Bassett

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.
5. 28 TAC §134.600 requires preauthorization for specific treatments and services.

Denial Reasons

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

DOS December 16, 2020:

- B12-Services not documented in patients medical records.

- 5347-Documentation on the CMS1500 or UB04 is not supported by the information in the medical record.
- 4-The procedure code is inconsistent with the modifier used or a required modifier is missing.
- 5283-Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, provider's contract, or car
- 193, 90563-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 247-A payment or denial has already been recommended for this service.

DOS March 15, 2021:

- P12, 00223-Workers compensation jurisdictional fee schedule adjustment.
- 309-The charge for this procedure exceeds the fee schedule allowance.
- 190-Billing for report or record review exceeds reasonableness.
- 193, 90563-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 247-A payment or denial has already been recommended for this service.

DOS May 19, 2021:

- 150, 90168-Payment adjusted because the payer deems the information submitted does not support the level of service.
- B13, 90202-Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 247-A payment or denial has already been recommended for this service.
- 193, 90563-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

DOS June 15, 2021:

- 90409, 119-Benefit maximum for this time period or occurrence has been reached.
- 163-The charge for this procedure exceeds the unit value and/or the multiple procedure rules.
- B12-Services not documented in patients medical records.

DOS June 17, 2021:

- 90409, 119-Benefit maximum for this time period or occurrence has been reached.
- 163-The charge for this procedure exceeds the unit value and/or the multiple procedure rules.
- B12-Services not documented in patients medical records.
- B13, 90202-Previously paid. Payment for this claim/service may have been provided in a previous payment.

- 247-A payment or denial has already been recommended for this service.
- 29-The time limit for filing has expired.
- 4271-Per TX Lavor Code Sec. 408.027, providers must submit bills to payors within 95 days of the date of service.
- 193, 90563-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is Indemnity Insurance Co. of North America's denial of payment for CPT code 99214 rendered on December 16, 2020 based on a lack of information supported?
2. Is Dr. James Mitchell entitled to reimbursement for work status reports, CPT code 99080-73?
3. Is Dr. James Mitchell entitled to reimbursement for office visits, CPT code 99213?
4. Is Indemnity Insurance Co. of North America's denial of payment for CPT codes 97110-GP and 97112-GP based on "Benefit maximum for this time period or occurrence has been reached" supported?
5. Is Dr. James Mitchell entitled to reimbursement for physical therapy services, CPT code 97110-GP and 97112-GP?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $792.48 for disputed services rendered from December 16, 2020 through June 17, 2021.

   The respondent denied reimbursement for CPT code 99214 rendered on December 16, 2020 based on reason codes "B12-Services not documented in patients medical records," "5347-Documentation on the CMS1500 or UB04 is not supported by the information in the medical record," and "4-The procedure code is inconsistent with the modifier used or a required modifier is missing."

   The fee guideline for CPT code 99214 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."

   CPT code 99214 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 moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter."

   The division finds the submitted reports does not support billing code 99214, specifically moderate level of medical decision making; therefore, reimbursement is not recommended.

2. The respondent denied reimbursement for CPT code 99080-73 rendered on March 15, 2021based upon reason code "190-Billing for report or record review exceeds reasonableness."

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 §133.307(d)(2)(I) requires the respondent to submit documentation "If the medical fee dispute involves medical necessity issues, the insurance carrier must attach documentation that supports an adverse determination in accordance with §19.2005 of this title (concerning General Standards of Utilization Review)."

The respondent did not submit any documentation that supports an adverse determination in accordance with §19.2005 of this title (concerning General Standards of Utilization Review) to support denial based upon "190". The DWC finds the respondent did not support the "190" denial of payment.

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."

A review of the submitted documentation finds the requestor is due reimbursement of $15.00.

3. The respondent denied reimbursement for office visits, CPT code 99213 rendered on May 19, 2021 based upon reason codes "150, 90168-Payment adjusted because the payer deems the information submitted does not support the level of service.

   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 submitted report supports billed service; therefore, the respondent's denial of payment based upon "150," and "90168" is not supported.

   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."

- 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 respondent paid $0.00. The difference between MAR and amount paid is $163.14.

4. The respondent reduced reimbursement for the disputed physical therapy services based upon reason codes "90409, 119-Benefit maximum for this time period or occurrence has been reached," "163-The charge for this procedure exceeds the unit value and/or the multiple procedure rules," "B12-Services not documented in patients medical records."

   The EOBs 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.

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 submitted the preauthorization report dated April 1, 2021 approving six units of 97110 and two units of 97112 starting April 1, 2021 through October 1, 2021; therefore, reimbursement is supported.

5. As stated above, the respondent did not support the denial of payment for CPT codes 97110 - GP (X6) and 97112-GP (X2).

   - 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 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 = $248.22	$0.00	$248.22	
97112	1	$27.00*	$47.33	$55.02	$47.33 X 2 dates = $94.66	$94.66 + 125.42 = $220.08 less $55.02 = $165.06
97112	1	$35.77	$62.71		$62.71 X 2 dates = $125.42	

*MPPR applies

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 $591.42 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 Indemnity Insurance Co. of North America must remit to Dr. James Mitchell $591.42 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		01/31/2022
Signature	Medical Fee Dispute Resolution Officer	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.