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
SCENIC MOUNTAIN MEDICAL CENTER

Respondent Name
LIBERTY INSURANCE CORPORATION

MFDR Tracking Number
M4-22-1056-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
February 2, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 9, 2021 through August 31, 2021	97032, 97035 and 97110	$433.48	$433.48
	Total	$433.48	$433.48

Requestor's Position

"The bill has been underpaid according to our fee schedule calculations."

Amount in Dispute: $433.48

Respondent's Position

"The bill for DOS 8/9/2021 to 8/31/2021 has been reviewed and denial stands as therapeutic exercise and activities are essential for rehabilitation. The use of modalities as stand-alone treatment is not Indicated as a sole approach to rehabilitation. Therefore, an overall course of rehabilitative treatment is expected to consist predominantly of therapeutic procedures (such as therapeutic exercises, neuromuscular re-education, gait training therapy, or therapeutic activities), with adjunctive use of modalities, This bill does not have any Therapeutic Exercise billed··· the only treatment billed is for use of modalities with CPT 97032 and 97035."

Response Submitted by: Liberty Mutual Insurance

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 (TAC) §133.307 sets out the Medical Fee Dispute Resolution guidelines.
2. 28 TAC §134.203 sets out the fee guideline for professional medical services.
3. 28 TAC §134.403 sets out the outpatient Facility Fee Guidelines.
4. 28 TAC §134.600 sets out the guidelines for preauthorization, concurrent utilization review and voluntary certification of health care.

Denial Reasons

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

- 163 - THE CHARGE FOR THIS PROCEDURE EXCEEDS THE UNIT VALUE AND/OR THE MULTIPLE PROCEDURE RULES.
- 170 - REIMBURSEMENT IS BASED ON THE PHYSICIAN FEE SCHEDULE WHEN A PROFESSIONAL SERVICE WAS PERFORMED IN THE FACILITY SETTING
- 246 - THIS PROCEDURE IS INAPPROPRIATELY BILLED. IT SHOULD ONLY BE BILLED IN CONJUNCTION WITH APPROPRIATE REQUIRED CODE.
- 3411 - SOLE COMMUNITY HOSPITAL OR ESSENTIAL ACCESS HOSPITAL PAYMENT ADJUSTMENT APPLIED.

Issues

1. Is the Insurance Carrier's denial reason supported?
2. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks additional reimbursement for outpatient physical therapy services rendered in a facility setting on August 9, 2021 through August 31, 2021. The insurance carrier denied/reduced the disputed services with denial reduction codes indicated above (description provided above.)

   The insurance carrier's audit denied/reduced the services in dispute with reduction code 163 (description provided above.) Review of the documentation submitted supports that the services in dispute were rendered as authorized. The documentation supports that the number of units were provided were preauthorized.

Per 28 TAC §134.600, preauthorization is required for physical therapy services. Review of the preauthorization letter dated July 22, 2021 issues by MediCall states the following:

"UR Determination

The prospective request for 20 Sessions of Physical Therapy for the … to include 97110, 97530, 97032, 97035, 97140 between 07/19/2021 to 09/17/2021 is modified to 9 sessions of Physical Therapy for the … to include 97035 and 97032."

The requestor seeks reimbursement for CPT code 97032, 97035 and 97110 rendered on August 9, 2021 through August 31, 2021. The DWC finds that the insurance carrier's denial reasons are not supported. The DWC finds that the requestor submitted sufficient documentation to support that preauthorization was obtained for CPT Codes 97032 and 97035, as a result, the requestor is entitled to reimbursement for these CPT Codes.

The DWC finds, that preauthorization was not obtained for CPT Code 97110, rendered on August 11, 2021, as a result, additional reimbursement cannot be recommended for CPT Code 97110.

2. The applicable Division Rule is found at 28 TAC §134.403. The applicable sections are listed below:

> (d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided.
>
> (h) For medical services provided in an outpatient acute care hospital, but not addressed in the Medicare payment policies as outlined in subsections (f)(1) or (f)(2) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided.

The OPPS reimbursement formula factors are found at https://www.cms.gov/Medicare/Medicare-Fee-forService-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html

The specific factor is the Status Indicators. The status indicator for each of the HCPCs code listed on the DWC060 have an "A" status indicator which is defined as, "Not paid under OPPS. Paid by MACs under a fee schedule or payment system other than OPPS."

Based on the requirements of 28 TAC §134.403 (h) the applicable Division fee guideline is found in 28 TAC §134.203.

Compliance with 28 TAC §134.403 (d) requires application of the Medicare Multiple Procedure Payment Reduction (MPPR) implemented April 1, 2013. The MPPR policy may be found in the CMS Claims Processing Manual 100-04, Chapter 5, section 10.7 found at www.cms.gov. The MPPR policy was used in the calculation of the maximum allowable reimbursement shown below.

28 TAC §134.203(b)(1) states, "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 Medicare Multiple Procedure Payment Reduction file is found at:
https://www.cms.gov/Medicare/Billing/TherapyServices/index.html

The Medicare payment policy regarding multiple procedure payment reduction is found in the Centers for Medicare and Medicaid Claims Processing Manual, Chapter 5, which states in applicable section 10.7:

> Medicare applies an MPPR to the PE payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The MPPR applies to all therapy services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, for example, physical therapy, occupational therapy, or speech-language pathology.
>
> **Full payment is made for the unit or procedure with the highest PE payment**. 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.

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 2021 the codes subject to MPPR are found in CMS 1615 the CY 2021 PFS Final Rule Multiple Procedure Payment Reduction Files. Review of that list find that codes 97032 and 97035 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.

CPT Code	Practice Expense	Medicare Policy
97035	0.20	Highest rank, no MPPR for first unit
97032	0.17	MPPR applies

As shown above, CPT Code 97035 has the highest PE payment amount 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 the carrier and locality.
- The services were provided in Big Spring, TX.
- The locality is "Rest of Texas."
- Using the above formula, the MAR amount for the first unit of CPT Code 97035 is $24.89.

CPT Code	CMS MPPR Payment	MPPR MAR
97035	$10.86	$19.04
97032	$11.76	$20.62

28 TAC §134.203 states in pertinent part, "(c) 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..."

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

- The 2021 DWC Conversion Factor is 61.17
- The 2021 Medicare Conversion Factor is 34.8931

Date of Service	CPT Code	# Units	MAR	Insurance Carrier Paid	Amount Due
August 9, 2021	97032-GP	2	$20.62 x 2 = $41.23	$0.00	$41.23
August 9, 2021	97035-GP	1	$24.89	$0.00	$24.89
	97035-GP	1	$19.04	$0.00	$19.04
August 11, 2021	97032-GP	2	$20.62 x 2 = $41.23	$44.18	$0.00
August 11, 2021	97035-GP	1	$24.89	$20.39	$4.50
August 17, 2021	97032-GP	3	$20.62 x 3 = $61.85	$0.00	$61.85
August 17, 2021	97035-GP	1	$24.89	$0.00	$24.89
August 19, 2021	97032-GP	3	$20.62 x 3 = $61.85	$0.00	$61.85
August 19, 2021	97035-GP	1	$24.89	$0.00	$24.89
August 23, 2021	97032-GP	3	$20.62 x 3 = $61.85	$0.00	$61.85
August 23, 2021	97035-GP	1	$24.89	$0.00	$24.89
August 25, 2021	97032-GP	3	$20.62 x 3 = $61.85	$0.00	$61.85
August 25, 2021	97035-GP	1	$24.89	$0.00	$24.89
August 31, 2021	97032-GP	3	$20.62 x 3 = $61.85	$0.00	$61.85
August 31, 2021	97035-GP	1	$24.89	$0.00	$24.89
TOTAL			$584.57	$64.57	$523.36

3. The DWC finds that the MAR reimbursement is $523.36 for CPT Codes 97032 and 97035 rendered on August 9, 2021 through August 31, 2021. The insurance carrier paid $0.00. The requestor seeks $433.48, applicable 28 TAC 134.203(h) states that the total reimbursement is the lesser of the maximum allowable reimbursement (MAR) and the billed amount, as a result the requestor is entitled to $433.48. Therefore, this amount is recommended.

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.

The DWC finds the requester has established that reimbursement of $433.48 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor $433.48 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		April 14, 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.