TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
PEAK INTEGRATED HEALTHCARE

Respondent Name
OLD REPUBLIC INSURANCE COMPANY

MFDR Tracking Number
M4-22-2037-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
May 16, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 14, 2021 through December 3, 2021	97710-GP, 97112-GP, and 97750-GP	$2,892.13	$2,224.72
	Total	2,892.13	$2,224.72

Requestor's Position

"The dates of service have been denied payment" per retro review, based on findings of review organization" , AND THEN AS AN 'EXACT DUPLICATE' This is incorrect. This patient has a compensable injury that has been paid on since these dates of service in full. See attached payment for same preauth on date of service 12/08/2021. I have attached this preauth #5080072 or your reference."

Amount in Dispute: $2,892.13

Respondent's Position

"The review of the bills have been completed. Attached is an updated spreadsheet with the finalized Case ID# information of the charges that were reprocessed and allowed. For Dates of Service 10/14/21 and 11/4/21 (Billed Charge $482.16), the denial of each date is being upheld: The provider submitted documentation that supports the billing of an FCE exam and not a PPE exam."

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 (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the fee guideline for professional medical services.
3. 28 TAC §134.240 sets out the guidelines for medical payment and denials.
4. 28 TAC §137.100 sets out the treatment guidelines.
5. 28 TAC §19.2003 sets out the utilization review definitions.
6. 28 TAC §134.600 sets out the preauthorization guidelines for specific treatments and services.

Denial Reasons

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

- 90147 & 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
- 216 – Based on the findings of a review organization.
- ADJ: Per retrospective review.
- 90403 – Payment adjusted as not furnished directly to the patient and/or not documented.
- 119 – Benefit maximum for this time period or occurrence has been reached.
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
- ZK10 – Resolution manager denial.
- 103 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules.
- 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
- 10 – The billed services requires the use of a modifier code.

Issues

1. Is the Insurance Carrier's denial reason for CPT Code 97750-GP rendered on October 14, 2021 and November 4, 2021 supported?
2. Is the insurance Carrier's denial reason for denying CPT Code 97110-GP and 97112-GP supported?
3. Does the MPPR apply to disputed CPT Codes 97750-GP, 97110-GP an 97112-GP?
4. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 97750-GP rendered on October 14, 2021 and November 4, 2021. The insurance carrier denied the dispute service with denial reduction code "216-Based on the findings of a review organization" and "ADJ-Per retrospective review."

   DWC Rule 28 TAC §137.100 (e) states, "An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017."

   Retrospective utilization review is defined in 28 TAC §19.2003 (b)(31) as, "A form of utilization review for health care services that have been provided to an injured employee. Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted."

   Additionally, 28 TAC §133.240 (q) states, in relevant part, "When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title and when the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title …, including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor ..."

   Submitted documentation does not support that the insurance carrier followed the appropriate procedures for a retrospective review denial of the disputed services outlined in §19.2003 (b)(31) or §133.240 (q). Therefore, the insurance carrier did not appropriately raise medical necessity for this dispute and the disputed charges are therefore eligible for reimbursement.

2. The requestor seeks reimbursement for CPT Codes 97710-GP and 97112-GP rendered on October 14, 2021 through December 3, 2021. The insurance carrier denied/reduced the disputed services with reduction code 216 – Based on the findings of a review organization.

   The DWC finds that the requestor submitted a request for preauthorization for CPT Codes 97110-GP and 97112-GP and the UR authorized 6 visits (97110 x 6, 97112 x 2) with a start date of 10/2021 and an end date of 4/2022.

   The DWC finds that the requestor submitted a second request for preauthorization for CPT Codes 97110-GP and 97112-GP and the UR authorized 10 visits (97110 x 6, 97112 x 2) with a start date of 11/2021 and an end date of 5/2022.

   Per 28 TAC §134.600 (p)(5) 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."

Per 28 TAC §134.600 (c)(1)(B) states, "The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care…"

The DWC finds that the requestor obtained preauthorization for CPT Codes 97110 and 97112, as a result, the insurance carrier's denial reason "216" is not supported. The DWC finds that the requestor is entitled to reimbursement for CPT Code 97110-GP and 97112-GP.

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 requestor billed the following CPT Codes 97750-GP, 97110-GP, and 97112-GP. The definition of each code is indicated below:

   CPT Code 97750-GP is defined as "Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes."

   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 97712 – "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 the disputed services. The "GP" modifier is described as "Services delivered under an outpatient physical therapy plan of care."

   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. The DWC finds that CPT Codes 97750, 97110 and 97112 are subject to the MPPR policy.

The chart below outlines the ranking for PE payment for each of the codes billed by the health care provider.

CPT Code	Practice Expense
97110	0.40
97112	0.49
97750	0.52

As shown above CPT Code 97712 has the highest PE payment amount for the services billed by the provider that day. As a result, the requestor is entitled to the MPFS for the first unit of CPT Code 97112 and MPPR applies to all other subsequent units billed.

CPT Code 97750 was billed with no other CPT Code on October 14, 2021 and November 4, 2021. As a result, the requestor is entitled to the MPFS for the first unit and MPPR applies to the subsequent units billed.

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..."

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 services were provided in zip code 75043; therefore, the Medicare locality is "Dallas, Texas."
- The 2021 DWC Conversion Factor is 61.17
- The 2021 Medicare Conversion Factor is 34.8931

CPT Code	Medicare physician Fee Schedule (MPFS) (1st unit)	MPFS MPPR for subsequent units	MAR (1st unit)	MAR for subsequent units
97750	$35.06	$25.75	$61.46	$45.14
97112	$35.77	$27.00	$61.55	$47.33
97110	__	$23.60	$41.37	$41.37

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

Date of Service	CPT Code	# Units	MAR	Insurance Carrier Paid	Amount Sought	Recommended Amount
10/14/21	97750	8	$377.45	$0.00	$482.16	$377.45
10/27/21	97110	6	$248.23	$0.00	$323.52	$248.23
	97112	2	$108.88	$0.00	$125.42	$108.88
10/29/21	97110	6	$248.23	$206.85	$116.67	$41.38
	97112	2	$108.88	$110.04	$15.38	$0.00
11/4/21	97110	6	$248.23	$0.00	$323.52	$248.23
	97112	2	$108.88	$0.00	$125.42	$108.88
11/4/21	97750	8	$377.45	$0.00	$482.16	$377.45
12/1/21	97110	6	$248.23	$0.00	$323.52	$248.23
	97112	2	$108.88	$0.00	$125.42	$108.88
12/3/21	97110	6	$248.23	$0.00	$323.52	$248.23
	97112	2	$108.88	$0.00	$125.42	$108.88
Totals		56	$2,540.45	$316.9	$2,892.13	$2,224.72

4. The DWC finds that the requestor is therefore entitled to a total recommended amount of $2,224.72. 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 $2,224.72 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 $2,224.72 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		August 5, 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.