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
ALLMERICA FINANCIAL BENEFITS

MFDR Tracking Number
M4-22-2047-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
May 17, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 27, 2021 and November 17, 2021	99213, 99080-73, 97710-GP and 97112-GP	$627.08	$536.41
	Total	$627.08	$536.41

Requestor's Position

"Office visits are recommended as determined to be medically necessary. Evaluation and management outpatient visits to the offices of medical doctors play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged… The attached 11/17/2021 date of service was reduced unjustly as 'Exceeds the amount indicated in the fee schedule' and 'the usual treatment in the home or office setting is 30-45 minutes. The medical necessity of services for an unusual length of time must be documented' which is INCORRECT… Per Rule 134.600, the carrier shall not withdraw preauthorization once issued."

Amount in Dispute: $627.08

Respondent's Position

The Austin carrier representative for Allmerica Financial Benefits Insurance Company is JT Parker & Associates. JT Parker & Associates was notified of this medical fee dispute on May 24, 2022. Rule §133.307(d)(1) states that if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC 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 (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 §134.239 sets out the guidelines for billing for work status reports.
4. 28 TAC §129.5 sets out the guidelines for work status reports.

Denial Reasons

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

- DNY0 – Denied per claim instructions.
- W3 – No additional reimbursement allowed after review of appeal/reconsideration.
- P12 – Denial after reconsideration.
- DNYA – Denied as claim is non-compensable.
- APRV – The Provider's charges were reviewed with consideration of the Payer's UR/Preauthorization Decision(s) governing this claimant. The listed Allowance reflects the result(s) of their Decision(s) and all applicable Bill Review Decision(s).

Issues

1. Is the Insurance Carrier's denial of compensability supported?
2. What is the definition of CPT Code 99213, 99080-73, 97110-GP and 97112-GP?
3. What is the fee guideline for CPT Code 99213?
4. What is the fee guideline for CPT Code 99080-73?
5. Does the MPPR apply to CPT Codes 97110-GP and 97112-GP?
6. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Codes 99213, 99080-73, 97110-GP and 97112-GP rendered on October 27, 2021 and November 17, 2021. The insurance carrier denied the disputed service with denial reduction codes indicated above.

   The service in dispute was denied by the workers' compensation carrier due to an unresolved compensability issue. 28 TAC §133.305(b) states that if a dispute over the compensability of a covered work injury exists for the same service for which there is a medical fee dispute, the dispute regarding the compensability shall be resolved prior to the submission of a medical fee dispute.

Review of the documentation submitted, finds that the insurance carrier did not provided documentation to the DWC to support that it filed a Plain Language Notice (PLN) regarding the disputed conditions as required by28 TAC §133.307(d)(2)(H). The respondent did not submit information to MFDR, to support that the PLN had ever been presented to the requestor or that the requestor had otherwise been informed of PLN prior to the date that the request for medical fee dispute resolution was filed with the DWC; therefore, the DWC finds that the compensability denial was not timely presented to the requestor in the manner required by 28 TAC §133.240. Because the service in dispute does not contain an unresolved compensability issue, this matter is eligible for review of a medical fee under 28 TAC §133.307. For that reason, this matter is addressed pursuant to the applicable rules and guidelines.

2. The requestor seeks reimbursement for CPT Codes 99213 and 99080-73 rendered on October 27, 2021 and CPT Codes 97710-GP and 97112-GP rendered on November 17, 2021.

   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."

   CPT Code 99213 is defined as, "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."

   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."

   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 DWC finds that the requestor rendered the services as billed, as a result, reimbursement is recommended for the disputed services.

3. The requestor seeks reimbursement for CPT Codes 99213 rendered on October 27, 2021.

   Per 28 TAC §134.203 sets out the guidelines for office visits.

   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
- Per the medical bills, the services were rendered in zip code 75006; therefore, the Medicare locality is "Dallas, Texas."
- The Medicare Participating amount for CPT code 99213 at this locality is $93.06.
- Using the above formula, the DWC finds the MAR is $163.14.
- The respondent paid $0.00.
- Reimbursement of $163.14 is recommended.

4. The requestor seeks reimbursement for CPT Code 99080-73 rendered on October 27, 2021.

   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 DWC finds that the requestor is entitled to $15.00 for the DW73, as a result this amount is recommended.

5. The requestor seeks reimbursement for CPT Codes 97110-GP x 6 and 97112-GP x 2 rendered on November 17, 2021.

   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 appended the "GP" modifier to both codes. 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 (MPPR) 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 2021 the codes subject to MPPR are found in CMS 1693F the CY 2021 PFS Final Rule Multiple Procedure Payment Reduction Files. Review of that list find that CPT Codes 97110 x 6 and 97112 x 2 are subject to the MPPR policy.

Review of the Medicare published list for 2021 finds that the PE RVU for CPT Code 97112 is 0.49 and the PE RVU for CPT Code 97110 is 0.40.

As shown above CPT Code 97112 has the highest PE RVU of 0.49 on that day, therefore, the reduced PE payment applies to all other services.

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.

The MPPR rates are published by carrier and locality.

CPT Codes	Medicare Fee Schedule (1st unit)	MPPR for subsequent units
97112	35.77 x 1 unit	$27.00 x 1 unit
97110	----------	$23.60 x 6 units

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
- Per the medical bills, the services were rendered in 75006, TX; therefore, the Medicare locality is "Dallas."

Dates of Service	CPT Code	# Units	MAR	Insurance Carrier Paid	Amount Sought	Recommended Amount
11/17/21	97112	1	$62.71	$0.00	$125.42	$110.04
	97112	1	$47.33	$0.00		
11/17/21	97110	6	$248.23	$0.00	$323.52	$248.23
Totals		8		$0.00	$448.94	$358.27

The DWC finds that the requestor is therefore entitled to a total recommended amount of $358.27, for CPT Codes 97112 and 97110.

6. The DWC finds that due to the reasons indicated above, the requestor is entitled to a total reimbursement amount of $536.41. 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 $536.41 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 $536.41 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		August 30, 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.