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
SAFETY NATIONAL CASUALTY CORP.

MFDR Tracking Number
M4-23-0038-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 1, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 29, 2021 through January 27, 2022	99204, 99213, 99080-73, 97110-GP, and 97112-GP	$870.62	$169.01
	Total	$870.62	$169.01

Requestor's Position

"The above date of service was not paid and has been returned due to reason: 'Documented procedure does not appear to match the code description/services not documented.' 'Workers' Compensation jurisdictional fee schedule adjustment.' This is incorrect. The medical records show all of the codes billed for were completed. I am also resubmitting this medical bill because it was not paid in accordance with the 2022 fee schedule. The charge does not exceed the fee schedule."

Amount in Dispute: $870.62

Respondent's Position

"The Austin carrier representative for Safety National Casualty Corporation is Flahive Ogden & Latson. Flahive Ogden & Latson was notified of this medical fee dispute on September 7, 2022. 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 was decided in accordance with the 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.

Denial Reasons

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

- 150 & 90168 – Payment adjusted because the payer deems the information submitted does not support this level of service.
- 5352 – CV: Service reduced/denied as level of E&M code submitted is not supported by documentation.
- 90563 & 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 5283 – Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, providers contract.
- 90409 & 119 – Benefit maximum for this time period or occurrence has been reached.
- P12 & 90223 – Workers' compensation jurisdictional fee schedule adjustment.
- 163 – The charge for this procedure exceeds the unit value and/or multiple procedure rules.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 5721 – To avoid duplicate bill denial for all reconsiderations/adjustments/additional payment requests submit a copy of this EOR…
- B13 & 90202 – Previously paid, payment for this claim/service may have been provided in a previous payment.
- 247 – Payment or denial has already been recommended for this service.
- B12 & 90201 – Services not documented in patients' medical records.

Issues

1. What is the description of the disputed services?
2. Is the Requestor entitled to reimbursement for CPT 99080-73?
3. Is the requestor entitled to reimbursement for CPT codes 99204 and 99213 supported?
4. Is the requestor entitled to reimbursement for CPT codes 97110-GP and 97112-GP?
5. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Codes 99204, 99213, 99080-73, 97110-GP and 97112-GP rendered on November 29, 2021, January 11, 2022, and January 27, 2022.

   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 99204 is described as "Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, **45**-**59** minutes of total time is spent on the date of the encounter."
   - 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 Division specific form DWC 73, Work Status Report.
   - CPT Code 97110-GP is described as "Therapeutic procedure, 1 or more areas, each **15** minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility."
   - CPT Code 97112-GP is described as "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."
   - Modifier -GP is described as, "Services delivered under an outpatient physical therapy plan of care."

2. The requestor billed CPT Code 99080-73 on January 11, 2022. The insurance carrier denied the disputed service with denial reasons codes 90202, B13, 247 (descriptions indicated above).

   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 that the insurance carrier issued a payment in the amount of $15.00 on February 2, 2022 under check #0177018270, as a result, additional reimbursement is not recommended.

3. The insurance carrier denied CPT Code 99204 and issued a payment for CPT Code 99213, the remaining charges were denied/reduced with denial reason codes indicated below.

   CPT Code 99204 rendered on 11/29/2021 was denied with denial/reduction codes;

   - 90168 & 150 – Payment adjusted because the payer deems the information submitted does not support this level of service
   - 5352 – CV: Service reduced/denied as level of E&M code submitted is not supported by documentation
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - 5283 – Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, providers contract

   Review of the submitted documentation finds that the requestor has not documented the level of service for CPT code 99024. As a result, the insurance carrier's denial reasons are supported and the requestor is therefore not entitled to reimbursement for CPT code 99204.

   CPT code 99213 rendered on January 11, 2022 was denied with denial/reduction codes;

   - P12 & 90223 – Workers' compensation jurisdictional fee schedule adjustment
   - 309 – The charge for this procedure exceeds the fee schedule allowance.
   - 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

   Review of the submitted documentation supports that the insurance carrier issued a payment in the amount of $163.14 on February 7, 2022, Check #0177018270. The Medical Fee Guideline amount for CPT code 99213 is $163.14. As a result, the requestor is not entitled to additional reimbursement.

4. The insurance carrier issued partial payments for CPT Codes 97110-GP and 97112-GP and denied the remaining charges with denial reason codes indicated below.

   CPT code 97110 x 6 units rendered on January 27, 2022 was denied with denial/reduction codes;

   - B12 & 90201 – Services not documented in patients' medical records.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 309 – The charge for this procedure exceeds the fee schedule allowance.
   - 90563 & 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - IC Paid $42.25 February 25, 2022, Check #0177471506

- IC Paid $42.25 on July 13, 2022, Check #0180625721
- The Requestor billed $330.42 for 6 units.
- The DWC finds that the Respondent issued payments totaling $84.50 for 2 units.
- Reimbursement for the additional 4 units is determined in accordance with 28 TAC §134.203.

CPT code 97112 x 2 units rendered on January 27, 2022, was denied with denial/reduction codes;

- B12 & 90201 – Services not documented in patients' medical records.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 90563 & 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- IC Paid $64.04 on February 25, 2022 under check #0177471506
- IC Paid $64.04 on July 13, 2022, Check #0180625721
- The Requestor billed $128.08 for two units.
- Reimbursement is determined in accordance with 28 TAC §134.203.

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…"

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 2022 the codes subject to MPPR are found in CMS 1693F the CY 2022 PFS Final Rule Multiple Procedure Payment Reduction Files. Review of that list find that CPT code 97112 has a PE RVU of 0.49, and CPT Code 97110 has a PE RVU of 0.40, as a result 97112 has the highest PE RVU, and therefore the first unit of 97112 is eligible for the full payment and the remaining units are subject to the MPPR.

CPT Code	PE RVU	Medicare Fee Schedule (first unit)	MPPR for subsequent units
97112	0.49	$35.48	$26.78
97110	0.40	N/A	$23.41

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

Disputed service rendered in 2022

- The 2022 DWC Conversion Factor is 62.46
- The 2022 Medicare Conversion Factor is 34.6062
- Per the medical bills, the services, were rendered in zip code 75211; therefore, the Medicare locality is "Dallas."

The Medicare Participating amount for CPT code 97112 at this locality is $35.48 for the first unit and $26.78 for subsequent units.

- Using the above formula, the DWC finds the MAR is $64.04 x 1 unit and $48.33 x 1 unit for a total MAR of $112.37.
- The respondent paid $128.08.
- Additional reimbursement is not recommended.

The Medicare Participating amount for CPT code 97110 at this locality is $23.41 x 6 units.

- Using the above formula, the DWC finds the MAR is $42.25/unit x 6 units = MAR $253.51.
- The respondent paid $84.50.
- The requestor is therefore entitled to an additional payment in the amount of $169.01.

5. The DWC finds the requestor is therefore entitled to reimbursement in the amount of $169.01.

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 in this review.

The DWC finds the requester has established that reimbursement of $169.01 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the service in dispute. It is ordered that the Respondent must remit to the Requestor $169.01 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		April 3, 2023
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.