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
PEAK INTEGRATED HEALTHCARE

Respondent Name
SOUTHEASTERN FREIGHT LINES, INC.

MFDR Tracking Number
M4-23-0359-01

Carrier's Austin Representative
Box Number 48

DWC Date Received
October 12, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 2, 2022 through June 30, 2022	97110-GP, 97112-GP, 99213 and 97750-GP	$1,021.78	$0.00
	Total	$1,021.78	$0.00

Requestor's Position

"The patient has had no other PPE for this, and we have received no payment for this date of service. DWC rule 134.204(9) A maximum of 3 PPE'S for each compensable injury shall be billed and reimbursed... All necessary and supporting documentation is included with this reconsideration to properly justify/support the administered treatment still needing to be paid."

Amount in Dispute: $1,021.78

Respondent's Position

The Austin carrier representative for Southeastern Freight Lines, Inc., is Gallagher Bassett Services. Gallagher Bassett Services was notified of this medical fee dispute on October 18, 2022. 28 TAC §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 28 TAC §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.

Denial Reasons

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

- 90409 & 119 – Benefit maximum for this time period or occurrence has been reached.
- 163 & 309 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules.
- 90137 & 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 5322 – The office visit is included in the procedure and is not reimbursable.
- 90563 & 193 – Original payment decision is being maintained; upon review it was determined that his claim was processed properly.
- 5283 – Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines usual and customary policies provider's contract.
- 90483 & 112 – Service not furnished directly to the patient and/or not documented.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 90483 & 112 – Service not furnished directly to the patient and/or not documented.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 309 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules.
- 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 his claim was processed properly.

Issues

1. Did the insurance carrier issue payment for CPT Code 99213 rendered on May 2, 2022 and June 30, 2022?
2. Did the insurance carrier issue payment for CPT Codes 97110-GP, and 97112-GP rendered on May 2, 2022 and June 30, 2022 and 97750-GP rendered on June 6, 2022?
3. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 99213 rendered on May 2, 2022 and June 30, 2022. The insurance carrier submitted proof of payment for the disputed services. The DWC will determine if the insurance carrier issued a payment in accordance with 28 TAC §134.203.

   28 TAC 134.203 applies to the reimbursement of CPT Code 99213 rendered on May 2, 2022 and June 30, 2022.

   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).

   Services were provided in 2022

   - The 2022 DWC Conversion Factor is 62.46
   - The 2022 Medicare Conversion Factor is 34.6062
   - The service was rendered in zip code 75211; the Medicare locality is "Dallas."

   The Medicare Participating amount for CPT Code 99213 at this locality is $92.65.
   - Using the above formula, the DWC finds the MAR is $167.22.
   - The insurance carrier paid $167.22 for the date of service May 2, 2022.
   - The insurance carrier paid $167.22 for the date of service June 30, 2022.
   - The requestor is therefore due $0.00.

   The DWC finds that the insurance carrier issued a payment in accordance with the fee guidelines, as a result, additional reimbursement is not due for dates of service, May 2, 2022, and June 30, 2022.

2. The requestor seeks reimbursement for CPT Codes 97110-GP, and 97112-GP rendered on May 2, 2022 and June 30, 2022 and 97750-GP rendered on June 6, 2022. The insurance carrier submitted proof of payment for the disputed services. The DWC will determine if the insurance carrier issued a payment in accordance with 28 TAC §134.203.

   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."

Per the CMS, 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).
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> 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 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 Codes 97110, 97112 and 97750 are subject to the MPPR policy.

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

CPT Code	Practice Expense
97112	0.49
97110	0.40

As shown above CPT Code 97112 has the highest PE payment amount for the services billed by the provider on day May 2, 2022 and June 30, 2022, therefore, the reduced PE payment applies to all other services. CPT Code 97750-GP was rendered on June 6, 2022 and therefore the first unit is not reduced and the subsequent seven units are reduced pursuant to the Medicare MPPR edits.

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... (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 2022 services is found at https://www.cms.gov/Medicare/Billing/TherapyServices/index.html.

- MPPR rates are published by locality and carrier.
- The services were provided in zip code 75211, which is "Dallas".
- The carrier code for Texas is 4412 and the locality code for Dallas is 11.

Date of Service	CPT Code	Medicare Fee Schedule (first unit)	MPPR for subsequent units
May 2, 2022	97112 x 2 units	$35.48	$26.78
	97110 x 6 units	----------	$23.41
Date of Service	CPT Code	Medicare Fee Schedule (first unit)	MPPR for subsequent units
June 6, 2022	97750 x 1 unit	$34.77	
	97750 x 7 units	----------	$25.54
Date of Service	CPT Code	Medicare Fee Schedule (first unit)	MPPR for subsequent units
June 30, 2022	97112 x 2 units	$35.48	$26.78
	97110 x 6 units	----------	$23.41

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

Services were provided in 2022

- The 2022 DWC Conversion Factor is 62.46
- The 2022 Medicare Conversion Factor is 34.6062
- Per the medical bills, the service was provided in zip code 75211; the Medicare locality is "Dallas."

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 x 6 units = MAR $253.51.
- The insurance carrier paid $253.50 for the date of service May 2, 2022
- The insurance carrier paid $253.50 for the date of service June 30, 2022.
- The requestor is therefore due $0.00.

The DWC finds that the insurance carrier issued a payment in accordance with the fee guidelines, as a result, additional reimbursement is not due for dates of service, May 2, 2022, and June 30, 2022.

The Medicare Participating amount for CPT Code 97112 x 2 units at this locality is $35.48 for the first unit and $26.78 for the subsequent units.

- Using the above formula, the MAR is $64.04 for the first unit and $26.78 for the subsequent units, for a total recommended amount of $90.82.
- The insurance carrier paid $112.37 for the date of service May 2, 2022.
- The insurance carrier paid $112.37 for the date of service June 30, 2022.
- The requestor is therefore due $0.00.

The DWC finds that the insurance carrier issued a payment in accordance with the fee guidelines, as a result, additional reimbursement is not due for dates of service, May 2, 2022, and June 30, 2022.

The Medicare Participating amount for CPT Code 97750 at this locality is $34.77 for the first unit and $25.54 for the subsequent units.

- Using the above formula, the DWC finds the MAR is $62.76 for the first unit and $46.10 for the subsequent 7 units, for a total recommended amount of $385.44.
- The insurance carrier paid $385.46.
- The requestor is due $0.00.

The DWC finds that the insurance carrier issued a payment in accordance with the fee guidelines, as a result, additional reimbursement is not due for dates of service June 6, 2022.

3. The DWC finds that the requestor has not established that additional reimbursement is due, as a result $0.00 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 not established that additional reimbursement is due. As a result, $0.00 is recommended.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

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.