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
NATIONAL UNION FIRE INSURANCE CO.

MFDR Tracking Number
M4-23-0360-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
October 12, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 16, 2022 through June 29, 2022	97110-GP, 97112-GP, 99213, and 99204	$826.02	$640.76
	Total	$826.02	$640.76

Requestor's Position

"The above dates of service were denied payment due to 'the benefit for this service is included in payment allowance for another service.' This is incorrect. The office visits for these dates of service remain unpaid. Therefore, we argue that these dates of service should be paid for in full. The patient is entitled to reasonable medical care as stipulated in Texas law as related to the original injury. 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."

Amount in Dispute: $826.02

Respondent's Position

The Austin carrier representative for National Union Fire Insurance Company, is Flahive, Ogden & Latson. Flahive, Ogden & Latson 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 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:

- 90409 & 119 – Benefit maximum for this time period or occurrence has been reached.
- 193 & 90563- Original payment decision is being maintained; upon review it was determined that his claim was processed properly
- 163 – 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.
- 5283 – Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines usual and customary policies provider's contract.
- 90072 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
- 4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.
- 5374 – CV: E&M service documented does not meet CPT requirements for modifier-25. Service should not be billed separately.
- 5322 – The office visit is included in the procedure and it is not reimbursable.
- 90168 & 150 – Payment adjusted because the payer deems the information submitted does not support this level of service
- 5352 - CV: Services reduced/denied as level of E&M code submitted is not supported by documentation.

Issues

1. What rules apply to the disputed services?
2. Is the requestor entitled to reimbursement for CPT Code 99213 and 99204?
3. Is the requestor entitled to reimbursement for CPT Codes 97110-GP, and 97112-GP?
4. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Codes 99213, 97110-GP, 97112-GP, and 99204 rendered on May 16, 2022 through June 29, 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."

   The requestor billed CPT Code 99213, 99204, 97112-GP, and 97110-GP.

   - 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 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 97112 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."
   - CPT Code 97110 is described as, "Therapeutic procedure, 1 or more areas, each **15** minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility."
   - Modifier – GP is described as, "Services delivered under an outpatient physical therapy plan of care."

   The DWC finds that 28 TAC §134.203 applies CPT Codes 99213, 99204, 97110-GP, and 97112-GP.

2. CPT Codes 99213 rendered on June 15, 2022, and June 29, 2022 and CPT Code 99204 rendered on May 16, 2022, were denied with denial reasons:

   - 193 & 90563 – Original payment decision is being maintained; upon review it was determined that his claim was processed properly.
   - 90137 & 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 5283 – Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines usual and customary policies provider's contract.
   - 90072 – The procedure code is inconsistent with the modifier used or a required modifier is missing.

- 4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.

- 5374 – CV: E&M service documented does not meet CPT requirements for modifier-25. Service should not be billed separately.
- 5322 – The office visit is included in the procedure and it is not reimbursable.
- 90168 & 150 – Payment adjusted because the payer deems the information submitted does not support this level of service
- 5352 - CV: Services reduced/denied as level of E&M code submitted is not supported by documentation.

A review of the submitted documentation finds that office visits rendered on the disputed dates of service are not included or bundled with the CPT codes billed on the disputed dates of service.

A review of the submitted documentation for the office visits supports the level of service billed for CPT codes 99213 and 99204.

A review of the CMS-1500's does not document that a modifier was appended to the disputed office visit charges and a modifier was not required when billing for the office visits.

The DWC finds that the insurance carrier's denial reasons are not supported. The requestor is therefore entitled to reimbursement for the disputed 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 2022 DWC Conversion Factor for 2022 is 62.46
- The 2022 Medicare Conversion Factor is 34.6062
- Per the medical bills, the service was rendered in zip code 75211; the Medicare locality is "Dallas."

The Medicare Participating amount for CPT code 99213 in this locality is $92.65.

- Using the above formula, the DWC finds the MAR is $167.22.
- The respondent paid $0.00.
- The requestor seeks $167.22 for each date of service.
- The requestor is due $167.22 for date of service Jun 15, 2022 and $167.22 for date of service June 29, 2022, for a total MAR of $334.44.

The Medicare Participating amount for CPT code 99204 at this locality is $169.72.

- Using the above formula, the DWC finds the MAR is $306.32.
- The respondent paid $0.00.
- The requestor seeks $306.32.
- The requestor is due $306.32 for date of service May 16, 2022.

3. The requestor seeks additional reimbursement for CPT Codes 97112-GP and 97110-GP rendered on June 15, 2022 and June 29, 2022. The insurance carrier reduced the disputed services with the reduction codes indicated below.

    - 90409 & 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
    - 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules.

    The insurance carrier did not respond to the DWC060 request. A decision is therefore based on the information contained in the dispute at the time of review. The DWC will determine the MAR reimbursement for each disputed date of service to determine if the requestor is entitled to additional reimbursement.

    The 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.

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 found that CPT Codes 97110, and 97112 are subject to the MPPR policy.

The DWC finds that CPT 97112 and 97110 are subject to Medicare's MPPR. The chart below outlines the ranking for PE payment for each of the codes billed by the health care provider.

CPT Code	Practice Expense	Medicare Policy
97110	0.40	
97112	0.49	Highest PE

As shown above CPT Code 97112 has the highest PE payment amount for the services billed by the provider 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... (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.

- The service was rendered in zip code 75211; the Medicare locality is "Dallas."
- The carrier code for Texas is 4412 and the locality code for Dallas is 11.

CPT Code	Medicare Fee Schedule (1st unit)	MPPR for subsequent units
97110		$23.41
97112	$35.48	$26.78

The MAR is calculated using the following formula: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

In 2022, the service dates were provided.

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

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

- Using the above formula, the DWC finds the MAR is $42.25 x 6 units, $253.51.
- The respondent paid $253.60 for date of service June 15, 2022.
- The respondent paid $253.60 for date of service June 29, 2022.
- The requestor seeks an additional payment of $76.92 for each date of service.

- The requestor is therefore not entitled to additional reimbursement.

The Medicare Participating amount for CPT 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 DWC finds the MAR is $64.04 for the first unit and $48.33 for the subsequent units, for a total MAR amount of $112.37.
- The respondent paid $112.37 for date of service June 15, 2022.
- The respondent paid $112.37 for the date of service June 29, 2022.
- The requestor seeks an additional payment of $15.71 for each date of service.
- The requestor is therefore not entitled to additional reimbursement.

4. The DWC finds that the requestor is entitled to reimbursement for the disputed office visits. The requestor has established that reimbursement in the amount of $640.76 is due.

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. There was consideration of all evidence, even though not all of it was discussed in the decision.

The DWC finds the requester has established that reimbursement is due in the amount of $640.76.

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 $640.76 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		March 27, 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 the parties involved in the dispute at the same time the request is filed with the 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).