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
INDEMNITY INSURANCE COMPANY

MFDR Tracking Number
M4-23-0467-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
October 19, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 28, 2022	97110-GP, 97112-GP and 99213	$459.43	$426.81
August 25, 2022	99213 and 99080-73	$182.22	$45.50
	Total	$701.66 Should be $641.65	$472.31

Requestor's Position

"I have attached the authorization for these dates of service, We requested authorization for CPT codes 97110 AND 97112 before scheduling treatment. The units are for 6 units of 97110 and 2 units for 97112. Please note you approved these 12 sessions of physical therapy PREAJJTH #5521209 ALSO, SEE ATTACHED PAYMENT IN FULL, FROM 7/11/2022 DATE OF SERVICE FOR THE SAME PREAUTH."

Amount in Dispute: $701.66

Respondent's Position

The Austin carrier representative for Indemnity Insurance Company, is Downs & Stanford, P.C. Downs & Stanford, P.C., was notified of this medical fee dispute on October 25, 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 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules.
- 5403 – CV: The bill is qualified for the Clinical Validation Program, no reductions applied.
- 193 & 90563 – Original payment decision is being maintained; upon review it was determined that his claim was processed properly.
- P12 & 90223 – Workers' compensation jurisdictional fee schedule adjustment.
- 4063 – Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting.
- 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 it not reimbursable.
- 90201 & B12 – Services not documented in patient's medical records.
- 5397 – CV: CPT Code submitted is based on service time and documentation of time spent does not support the number of units billed. Services denied

Issues

1. What rules apply to the disputed services?
2. Is the requestor entitled to reimbursement for CPT Code 99213?
3. Is the requestor entitled to reimbursement for CPT Code 99080-73?
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 99213, 99080-73, 97110-GP, and 97112-GP rendered on July 28, 2022 and CPT Code 99213 rendered on August 25, 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, 97112-GP, and 97110-GP on July 28, 2022.

   - 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 "DWC-73-Work Status Report."
   - 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, 97110-GP, and 97112-GP.

2. CPT Codes 99213 rendered on July 28, 2022, and August 25, 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.
   - P12 & 90223 – Workers' compensation jurisdictional fee schedule adjustment.
   - 4063 – Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting.
   - 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 it not reimbursable.

   The DWC completed NCCI edits to identify potential edit conflicts for date of service Jul 28, 2022. The DWC finds that the CPT code 99213 billed on that day is not bundled and/or included in the payment amount for the PT services rendered on that day. As a result, the insurance carrier's denial reasons, "90137, 97 & 5322" are not supported.

The DWC completed NCCI edits to identify potential edit conflicts for date of August 25, 2022. Review of the medical documentation for CPT code 99213 billed on that day is not bundled and/or included in the payment amount for CPT code 99080-73. As a result, the insurance carrier's denial reasons, "90137, 97 & 5322" are not supported.

Review of the EOB dated September 13, 2022, finds that the insurance carrier issued a payment in the amount of $121.72 under check #0182062904 and denied the remaining charge.

A review of the submitted documentation for CPT Code 99213, finds that the requestor documented and billed CPT Code 99213 on disputed dates July 28, 2022 and August 25, 2022.

The DWC finds that the insurance carrier's denial reasons are not supported. The requestor is therefore entitled to additional/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).

CPT Code 99213 was rendered 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 rendered in zip code 75211; the Medicare locality is "Dallas."

The Medicare Participating amount for CPT code 99213 rendered on July 28, 2022 at 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.
- The requestor is due $167.22.

The Medicare Participating amount for CPT code 99213 rendered on August 25, 2022 at this locality is $92.65.

- Using the above formula, the DWC finds the MAR is $167.22.
- The respondent paid $121.72.
- The requestor seeks $167.22 .
- The requestor is due an additional payment amount of $45.50.

The requestor is therefore entitled to an additional payment in the amount of $212.72.

3. The requestor seeks reimbursement for CPT Code 99080-73 rendered on August 25, 2022. Review of the EOB dated September 13, 2022, finds that the insurance carrier issued a payment in the amount of $15.00 under check #0182062904.

   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 documentations finds that the insurance carrier issued a payment in the amount of $15.00; therefore, reimbursement is not recommended for this report.

4. The requestor seeks additional reimbursement for CPT Codes 97112-GP and 97110-GP rendered on July 28, 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.
   - 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules.
   - 5403 – CV: The bill is qualified for the Clinical Validation Program, no reductions applied.
   - 90201 & B12 – Services not documented in patient's medical records.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 5397 – CV: CPT Code submitted is based on service time and documentation of time spent does not support the number of units billed. Services denied

   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.

   Review of the submitted medical records supports that the requestor billed and documented the disputed CPT Codes, as a result, the insurance carrier's denial reasons are not supported.

   The DWC will determine the MAR reimbursement for each disputed CPT code 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 find 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 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.

- MPPR rates are published by carrier and locality.
- The service were 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

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

The date of service was rendered on July 28, 2022.

- 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 $42.25.
- The requestor seeks an additional payment of $228.17.
- The requestor is entitled to an additional payment of $211.26.

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 MAR amount of $112.37.
- The respondent paid $64.04.
- The requestor seeks an additional payment of $64.04.
- The requestor is entitled to an additional payment of $48.33.

5. The DWC finds that the requestor is entitled to reimbursement for the disputed services. The requestor has established that reimbursement in the amount of $472.31 is due. 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 is due in the amount of $472.31.

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 $472.31 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		March 21, 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).