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
OLD REPUBLIC INSURANCE COMPANY

MFDR Tracking Number
M4-23-0513-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
October 26, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 28, 2022 through September 20, 2022	99213, 97110-GP, 97112-GP, and 99080-73	$2,350.66	$1,980.19
	Total	$2,350.66	$1,980.19

Requestor's Position

"The above date of service was denied full payment stating "BILLED DIAGNOSIS NOT ALLOWED IN THIS CLAIM AND ABSENCE OF AUTHORIZATION." This is incorrect. These are the same diagnosis codes that are approved and have been paid on previously. See attached payment for 7/27/2022 with same allowable codes."

Amount in Dispute: $2,350.66

Respondent's Position

"At the outset it should be noted that per Texas Admin. Rule 133.307(f)(3)(C), 'The Division may dismiss a request for medical fee dispute resolution if the carrier has raised a dispute pertaining to compensability, extent of injury, or liability for the claim.' The claimant was sent to a Designated Doctor who found the work injury does not include injuries to the... Respondent respectfully requests consideration of its position stated herein and seeks continued denial of any reimbursement."

Response Submitted by: White Espey, PLLC

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:

- 219 – Based on extent of injury.
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 1014 – The attached billing has been re-evaluated we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 216 – Based on the findings of a review organization.
- P1 – These are adjustments initiated by the payer, for such reasons as billing errors or services that are not considered reasonable or necessary. The amounts adjusted is generally not the patient's responsibility unless the workers' compensation state law allows the patient to be billed.
- 18 – Exact duplicate claim/service.
- 247 – A payment denial has already been recommended for this service.
- N111 – No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.

Issues

1. Is the Insurance Carrier's denial of compensability supported?
2. Is the Insurance Carrier's denial of 216 supported?
3. What is the definition of CPT Code 99213, 99080-73, 97110-GP and 97112-GP?
4. What is the fee guideline for CPT Code 99213?
5. What is the fee guideline for CPT Code 99080-73?
6. Does the MPPR apply to CPT Codes 97110-GP and 97112-GP?
7. 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 February 28, 2022 through September 20, 2022. The insurance carrier denied the disputed service with denial reduction codes indicated above.

   The services in dispute were denied by the workers' compensation carrier due to an unresolved extent of injury 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 by 28 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 a PLN prior to the date that the request for medical fee dispute resolution was filed with the DWC; therefore, the DWC finds that the extent of injury denial was not timely presented to the requestor in the manner required by 28 TAC §133.240. Because the services in dispute do not contain an unresolved compensability issue, this matter is eligible for review under 28 TAC §133.307. For that reason, this matter is addressed pursuant to the applicable rules and guidelines.

2. The insurance carrier denied the disputed services with denial reduction code 219. The DWC finds that the requestor provided a copy of the preauthorization for the service in dispute. As a result, the DWC finds that the insurance carrier's denial reasons are not supported. The requestor is therefore entitled to reimbursement for the services provided.

3. The requestor seeks reimbursement for CPT Codes 99213 and 99080-73, 97110-GP and 97112-GP rendered on February 28, 2022 through September 20, 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 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 a division specific code and is described as "Work Status Report."

   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 requestor appended therapy modifier -GP which indicates physical therapy services.

4. The requestor seeks reimbursement for CPT Codes 99213 rendered on February 28, 2022, April 20, 2022, and September 20, 2022.

   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 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 99213 at this locality is $92.65.
   - Using the above formula, the DWC finds the MAR is $167.22.
   - The respondent paid $0.00.
   - Reimbursement of $167.22 x 3 DOS = total MAR of $501.67 is recommended.

5. The requestor seeks reimbursement for CPT Code 99080-73 rendered on September 20, 2022.

   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 DWC73, as a result this amount is recommended.

6. The requestor seeks reimbursement for CPT Codes 97110-GP x 6 and 97112-GP x 2 rendered on February 28, 2022, July 6, 2022, July 12, 2022, and July 14, 2022.

   The fee guidelines for the disputed services are 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 CPT Codes 97110 and 97112. 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 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 x 6 and 97112 x 2 are subject to the MPPR policy.

Review of the Medicare published list for 2022 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 2022 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 x 2	$35.48 x 1 unit	$26.78 x 1 unit
97110 x 6	----------	$23.41 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 2022 DWC Conversion Factor is 62.46
- The 2022 Medicare Conversion Factor is 34.6062
- Per the medical bills, the services were rendered in 75211, TX; therefore, the Medicare locality is "Dallas."

Dates of Service	CPT Code	# Units	MAR	Insurance Carrier Paid	Amount Sought	Recommended Amount
2/28/22	97112	1	$64.04	$0.00	$128.08	$112.37
	97112	1	$48.33	$0.00		
	97110	6	$253.51	$0.00	$330.42	$253.51
7/6/22	97112	1	$64.04	$0.00	$128.08	$112.37
	97112	1	$48.33	$0.00		
	97110	6	$253.51	$0.00	$330.42	$253.51
7/12/22	97112	1	$64.04	$0.00	$128.08	$112.37
	97112	1	$48.33	$0.00		
	97110	6	$253.51	$0.00	$330.42	$253.51
7/14/22	97112	1	$64.04	$0.00	$128.08	$112.37
	97112	1	$48.33	$0.00		
	97110	6	$253.51	$0.00	$330.42	$253.51
Totals			$1,463.52	$0.00	$1,834.00	$1,463.52

7. The DWC finds that the requestor is therefore entitled to a total recommended amount of $1,463.52 for CPT Codes 97112 and 97110, rendered on February 28, 2022 through July 14, 2022; $15.00 for CPT Code 99080-73 rendered on September 20, 2022, and $501.67 for CPT Codes 99213 rendered on February 28, 2022, April 20, 2022, and September 20, 2022.

   The DWC finds that due to the reasons indicated above, the requestor is entitled to a total reimbursement amount of $1,980.19. 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 $1,980.19 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 $1,980.19 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		February 6, 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.