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
MONROE GUARANTY INSURANCE COMPANY

MFDR Tracking Number
M4-23-0520-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
October 27, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 29, 2021 through February 10, 2022	99361-W1, 97110-GP, 97112-GP, 99213, 97750-GP, and 99080-73	$3,066.60	$2,377.76
	Total	$3,066.60	$2,377.76

Requestor's Position

"The attached dates of service were denied payment unjustly as 'not a work-related injury or illness which is incorrect.' This is INCORRECT as we have been billing for this work injury and have received multiple payments. I have attached a previous payment for the 10/19/2021 date of service."

Amount in Dispute: $3,066.60

Respondent's Position

The Austin carrier representative for Monroe Guaranty Insurance Company is JT Parker & Associates, LLC. JT Parker & Associates, LLC was notified of this medical fee dispute on November 1, 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.
3. 28 TAC §133.20 sets out the medical bill submission procedures for health care providers.
4. 28 TAC §102.4 sets out the rules for non-Commission communications.
5. 28 TAC §129.5 sets out the fee guidelines for billing and reimbursement for work status reports.
6. 28 TAC §134.220, provides the medical fee guidelines for case management service
7. TLC §408.027 sets out the rules for timely submission of claims by health care providers.
8. TLC §408.0272 provides for certain exceptions to untimely submission of a medical bill.

Denial Reasons

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

- P2 – Not a work-related injury/illness and thus not the liability of the workers' compensation carrier.
- 18 – Exact duplicate claim/service.
- Note: A healthcare provider shall not submit a new or corrected medical bill later than the 95th day after date of service.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 29 – The time limit for filing has expired.

Issues

1. What are the services in dispute?
2. Is the date of service December 16, 2021 eligible for review?
3. Is the insurance carrier's denial of liability supported?
4. Is the insurance carrier's timely filing denial supported?
5. Is the requestor entitled to reimbursement for CPT code 99361-W1?
6. Is the requestor entitled to reimbursement for CPT code 99213?
7. Is the requestor entitled to reimbursement for CPT codes 97110-GP, 97112-GP, and 97750-GP?
8. Is the requestor entitled to reimbursement for CPT code 99080-73?
9. What amount of payment is the Requestor due?

Findings

1. The requestor seeks reimbursement for CPT 99361-W1, 99213, 97110-GP, 97112-GP, 99080-73, and 97750-GP rendered on October 29, 2021 through February 10, 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 codes 99213, 97110-GP, 97112-GP, 99361-W1, 99080-73, and 97750-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 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."
   - 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 99361-W1 is described as, "Case Management."
   - CPT code 99080-73 is described as, "Work Status Report."
   - CPT code 97750 is described as, "Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each **15** minute."
   - Modifier – GP is described as, "Services delivered under an outpatient physical therapy plan of care."

   The DWC finds that 28 TAC §134.203 applies to the billing and reimbursement of CPT 99213, 97110-GP, 97112-GP, and 97750-GP.

   The DWC finds that 28 TAC §129.5 applies to the billing and reimbursement of CPT 99080-73 and 28 TAC §134.220 applies to the billing and reimbursement of CPT 99361-W1.

2. Review of the medical documentation submitted for date of service December 16, 2021 finds that the requestor seeks reimbursement for CPT codes 97110-GP, and 97112-GP. A review of the medical bills associated with this date of service finds that no EOBs were included for review for this date of service. The requestor submitted sufficient documentation to support that an initial bill and a request for reconsideration bill were submitted to the insurance carrier, prior to the submission of the MDR, the insurance carrier did not respond to either of the medical bills. The disputed date of service is therefore reviewed pursuant to the applicable rules and guidelines.

3. The insurance carrier denied the disputed services with denial reduction code, "P2 – Not a work-related injury/illness and thus not the liability of the workers' compensation carrier."

   A review of the DWC060 finds that the insurance carrier did not respond to the DWC060 request. A review is therefore conducted with the documents contained in the dispute at the time of review.

   28 TAC §133.305(b) states that if a dispute over the extent of a covered work injury exists for the same service for which there is a medical fee dispute, the dispute regarding the extent of injury shall be resolved prior to the submission of a medical fee dispute.

   Review of the documentation submitted by the parties finds that the carrier did not provide documentation to the Division to support that it filed a Plain Language Notice (PLN) regarding the disputed conditions as required by §133.307(d)(2)(H).

   The respondent did not submit sufficient information to MFDR, to support that the PLN had ever been presented to the requestor or that the requestor had otherwise been informed of 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 extent of injury issue, this matter is ripe for adjudication of a medical fee under 28 TAC §133.307. For that reason, this matter is addressed pursuant to the applicable rules and guidelines

4. The insurance carrier denied the disputed services with denial reduction code, "29 – The time limit for filing has expired."

   A review of the DWC060 finds that the insurance carrier did not respond to the DWC060 request. A review is therefore conducted with the documents contained in the dispute at the time of review.

   28 TAC §133.20(b) requires that, except as provided in TLC §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that any of the exceptions described in TLC §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not-later than 95 days after the date the disputed services were provided.

   TLC §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

   28 TAC §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

Review of the submitted information finds sufficient documentation to support that a medical bill was submitted within 95-days from the date the services were provided. Therefore, the DWC finds that the insurance carrier's denial reason is not supported. The disputed services are therefore eligible for review pursuant to 28 TAC §134.203.

5. The fee guidelines for CPT Code 99361-W1, rendered on October 29, 2021 is found at 28 TAC §134.220.

   28 TAC §134.220(1) states, "Case management responsibilities by the treating doctor are as follows: (1) Team conferences and telephone calls shall include coordination with an interdisciplinary team. (A) Team members shall not be employees of the treating doctor. (B) Team conferences and telephone calls must be outside of an interdisciplinary program. Documentation shall include the purpose and outcome of conferences and telephone calls, and the name and specialty of each individual attending the team conference or engaged in a phone call."

   The submitted "Team Conference" report does not document the purpose and outcome of the conference; it does not specify that the team members are not employees of the treating doctor; and that the conference was not part of an interdisciplinary program.

   The DWC finds the requestor did not comply with the requirements outlined in 28 TAC §134.220(1).

   28 TAC §134.220(2) states, "Case management responsibilities by the treating doctor are as follows: (2) Team conferences and telephone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee."

   The submitted "Team Conference" report does not document a change in the injured employee's condition or that it was performed for the purpose of coordination medical treatment and/or returning the injured employee to work.

   The DWC finds the requestor did not comply with the requirements outlined in 28 TAC §134.220(2).

   28 TAC §134.220(4) states, "Case management responsibilities by the treating doctor are as follows: (4) Case management services require the treating doctor to submit documentation that identifies any health care provider that contributes to the case management activity. Case management services shall be billed and reimbursed as follows: (A) CPT code 99361. (i) Reimbursement to the treating doctor shall be $113. Modifier "W1" shall be added." The requestor billed $113.00 for CPT code 99361-W1 in accordance with 28 TAC §134.220(4).

   Based upon the above findings the DWC finds the requestor is not entitled to reimbursement for CPT code 99361-W1 because the "Team Conference" report does not meet documentation requirements found in 28 TAC §134.220(1) and (2).

6. CPT code 99213 rendered on November 17, 2021 was denied with reason code;

    - 18 – Exact duplicate claim/service.

   A review of the medical documentation finds that the requestor documented and billed CPT Code 99213. The DWC finds that the insurance carrier's denial reason is not supported, as a result the requestor is entitled to reimbursement for CPT Code 99213.

   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 rendered in 2021

    - The 2022 DWC Conversion Factor is 61.17
    - The 2022 Medicare Conversion Factor is 34.8931
    - Review of the CMS1500, box thirty-two documents the service was rendered in zip code 75211; the Medicare locality for this zip code is "Dallas."

   The Medicare Participating amount for CPT code 99213 at this locality is $93.06.

    - Using the above formula, the DWC finds the MAR is $163.14.
    - The respondent paid $0.00.
    - The requestor is due $163.14.

7. CPT 97110-GP, 97112-GP, rendered on November 17, 2021, December 16, 2021, February 7, 2022, February 9, 2022, February 10, 2022, and CPT 97550-GP rendered on January 24, 2022, were denied with denial reduction code;

    - 18 – Exact duplicate claim/service

   Review of the submitted documentation finds that the insurance carrier's denial reason is not supported. The disputed service is therefore reviewed pursuant to the applicable rules and guidelines.

   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."

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 2021, the codes subject to MPPR are found in CMS 1693F the CY 2021 PFS Final Rule Multiple Procedure Payment Reduction Files. 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.

Reimbursement is determined for the following CPT Codes; 97110-GP, 97112-GP, rendered on November 17, 2021, December 16, 2021, February 7, 2022, February 9, 2022, February 10, 2022, and CPT Code 97550-GP rendered on January 24, 2022.

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

CPT Code	Practice Expense
97110	0.40
97112	0.49

As shown above CPT Code 97112 has the highest PE payment amount for the dates of service indicated above, therefore, the reduced PE payment applies to all other services.

The DWC determined that CPT Code 97750-GP is the only CPT Code billed on January 24, 2022, as a result 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. 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 2021 and 2022 services is found at https://www.cms.gov/Medicare/Billing/TherapyServices/index.html.

- Locality and carrier determine the Medicare MPPR rates.
- 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
11/17/21	97112 x 2 units	$35.77	$27.00
	97110 x 6 units	------------	$23.60
Date of Service	CPT Code	Medicare Fee Schedule (first unit)	MPPR for subsequent units
12/16/21	97112 x 2 units	$35.77	$27.00
	97110 x 6 units	------------	$23.60
Date of Service	CPT Code	Medicare Fee Schedule (first unit)	MPPR for subsequent units
1/24/22	97750 x 1	$34.77	------------
	97750 x 7	------------	$25.54
Date of Service	CPT Code	Medicare Fee Schedule (first unit)	MPPR for subsequent units
2/7/22	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
2/9/22	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
2/10/22	97112 x 2 units	$35.48	$26.78
	97110 x 6 units	------------	$23.41

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

CPT Codes 97110-GP and 97112-GP rendered on November 17, 2021 and December 16, 2021

- The 2021 DWC Conversion Factor is 61.17
- The 2021 Medicare Conversion Factor is 34.8931
- The CMS 1500, box thirty-two documents the disputed services were rendered in zip code 75211; the Medicare locality is "Dallas."

The Medicare Participating amount for CPT code 97110 at this locality is $23.60 x 6 units.

- Using the above formula, the DWC finds the MAR is $41.37 x 6 units, for a total MAR of $248.23.
- The respondent paid $0.00.
- The requestor is due $248.23 for date of service November 17, 2021.
- The requestor is due $248.23 for date of service, December 16, 2021.
- Total recommended reimbursement of $496.46.

The Medicare Participating amount for CPT code 97112 at this locality is $35.77 for the first unit and $27.00 for the subsequent units.

- Using the above formula, the DWC finds the MAR is $62.71 for the first unit and $47.33 for the subsequent unit for a total of $110.04.
- The respondent paid $0.00.
- The requestor is due $110.04 for date of service, November 17, 2021.
- The requestor is due $110.04 for date of service December 16, 2021.
- Total recommended reimbursement of $220.08.

CPT Codes 97110-GP and 97112-GP were rendered on February 7, 2022, February 9, 2022, and February 10, 2022.

- The 2022 DWC Conversion Factor is 62.46
- The 2022 Medicare Conversion Factor is 34.6062
- The CMS 1500, box thirty-two documents the services in dispute were rendered in zip code; the Medicare locality is "Dallas."

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

- Using the above formula, the DWC finds the MAR is $42.25 x 6 units = total MAR $253.51.
- The respondent paid $0.00.
- The requestor is due $253.51 for date of service, February 7, 2022.
- The requestor is due $253.51 for date of service, February 9, 2022
- The requestor is due $253.51 for date of service, February 10, 2022
- Total recommended reimbursement of $760.53.

The Medicare Participating amount for CPT code 97112 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 unit.
- The respondent paid $0.00.
- The requestor is due $112.37 for date of service, February 7, 2022.
- The requestor is due $112.37 for date of service, February 9, 2022.
- The requestor is due $112.37 for date of service, February 10, 2022.
- Total recommended reimbursement of $337.11.

The Medicare Participating amount for CPT 97750 x 8 units at this locality is $34.77 for the first unit and $25.54 x 7 units.

- Using the above formula, the DWC finds the MAR is for the first unit is $62.76 and $46.10 x 7 units = $322.67, for a total MAR of $385.44.
- The respondent paid $0.00.
- The requestor is due $385.44 for date of service, January 24, 2022.

8. CPT Codes 99080-73 rendered on November 17, 2021 was denied with denial reduction code;

    - 18 – Exact duplicate claim/service.

    Review of the submitted documentation finds the requestor documented and billed for CPT Code 99080-73. The DWC therefore finds that the insurance carrier's denial reason is not supported. The disputed service is therefore reviewed pursuant to the applicable rules and guidelines.

    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 Work Status Report was documented in accordance with 28 TAC §129.5; therefore, reimbursement of $15.00 is recommended for this report.

9. The DWC finds that the requestor has established that reimbursement in the amount of $2,377.76. The requestor is therefore due this amount.

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 is due in the amount of $2,377.76.

Order

Under Texas Labor Code §§413.031 and 413.019, the DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor $2,377.76 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

________________________	________________________	April 18, 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.