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 Co. of North America

MFDR Tracking Number
M4-23-0812-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
December 7, 2022

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
06/08/2022	99203	$205.43	$0.00
07/12/2022	97110-GP	$288.17	$211.26
07/12/2022	97112-GP	$64.04	$48.33
06/27/2022	99750-GP(sic) [97750-GP]	$502.08	$0.00
	Total	$1,059.72	$259.59

Requestor's Position

The following statements are extracted from requests for reconsideration…

Regarding 6/8/2022 disputed service: "… dates of service were incorrectly billed for. The HCFA has been corrected for the type of visit that was performed… see attached corrected claim reflecting this… FULL payment for the CPT code 99213, according to the 2022 fee schedule is $167.22….

Regarding 7/12/2022 disputed services: "… dates of service were denied payment initially due to 'WORKERS COMPENSATION JURISDICTIONAL FEE ADJUSTMENT' then upon reconsideration, denied for timely filing. This is incorrect… I have attached authorization for these dates of service. The units are for 6 units of 97110 and 2 units for 97112… Please note you approved these 6 sessions… "

Regarding 6/27/2022 disputed service: "This has been denied after billing stating, 'BENEFIT MAXIMUM HAS BEEN REACHED', AND 'MULTIPLE PROCEDURE RULES'. This is incorrect… The fee schedule allows for $502.08 to be charged for PHYSICAL PERFORMANCE EVALUATION that lasts 2 hours (8 units)… "

Amount in Dispute: $1,059.72

Respondent's Position

The Austin carrier representative for Indemnity Insurance Co of North America is Downs Stanford PC. The representative was notified of this medical fee dispute on December 12, 2022. Per 28 Texas Administrative Code §133.307 (d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information. As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

Response Submitted by: N/A

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. Texas Administrative Code(TAC) 28 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 health care provider billing procedures.

Denial Reasons

The insurance carrier denied payment for the disputed evaluation and management (E/M) CPT code 99203 rendered on 6/8/2022 with the following claim adjustment codes:

- 90096 – The time limit for filing has expired.
- 29 - The time limit for filing has expired.
- 4271 – Per TX Labor Code sec. 408.027, providers must submit bills to payors within 95 days of the date of service.

The insurance carrier reduced payment for the disputed therapy CPT codes 97110-GP x 6 units and 97112-GP x 2 unit, rendered on 7/12/2022, with the following claim adjustment codes:

- *90201 - Services not documented in patients' medical records.
- B12 - Services not documented in patients' 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. Service denied.

(*The division notes that the EOB dated 8/29/2022, shows an incorrect number of units as it is not consistent with the medical bills submitted with this dispute resolution request.)

- *90202 – Previously paid. Payment for this claim may have been provided in a previous payment.
- B13 - Previously paid. Payment for this claim may have been provided in a previous payment.
- 247 – A payment or denial has already been recommended for this service.

The insurance carrier denied payment for the disputed CPT code 97750-GP x 8 units rendered on 6/27/2022, with the following claim adjustment codes:

- *90403 – Service not furnished directly to the patient and/or not documented.
- 112 - Service not furnished directly to the patient and/or not documented.
- 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.
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

Issues

1. Is the requestor entitled to reimbursement for CPT Code 99203 rendered on June 8, 2022?
2. Is the requestor entitled to additional reimbursement for CPT Codes 97110-GP x six units and 97112-GP x two units, rendered on July 12, 2022?
3. Is the requestor entitled to reimbursement for CPT Code 97750-GP rendered on June 27, 2022?

Findings

1. The dispute concerns an evaluation and management service billed under CPT code 99203 which, per EOB dated 9/20/2022, was denied payment due to untimely filing of the medical bill.

   28 TAC §133.20 sets out Medical Bill Submission rules states in pertinent part "(b)Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided… "

   Review of submitted documentation finds that the insurance carrier (IC) received the bill for CPT code 99203 on 9/1/2022, 86 days from June 8, 2022, the date the service was rendered. The division finds that the bill was submitted to the IC in a timely manner in accordance with 28 TAC §133.20.

   The division finds that 28 TAC §134.203(b)(1) applies to reimbursement of disputed service CPT code 99203.

   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 99203 is defined 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 low level of medical decision making (MDM). When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter."

- The American Medical Association (AMA) CPT Code and Guideline Changes, effective January 1, 2021, can be found at: www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf. In summary, CPT 99203 documentation must contain all two out of three of the following elements: 1) low level of number and complexity of problems addressed 2) limited level of amount and/or complexity of data to be reviewed and analyzed 3) low risk of morbidity/mortality of patient management OR must document 30-44 minutes of total time spent on the date of patient encounter.
- An interactive E&M scoresheet tool is available at: www.novitas-solutions.com/webcenter/portal/MedicareJL/EMScoreSheet.
- A review of submitted medical documentation finds that a low level of MDM was not met in the elements of 1) Amount or complexity of data reviewed and analyzed 2) Risk of morbidity or mortality of patient management. Submitted medical record shows no documentation of time spent on date of encounter. For these reasons, medical documentation submitted did not meet AMA criteria for reimbursement of CPT code 99203.

The division finds that the requester's documentation does not support E/M level 99203 CPT code rendered on June 8, 2022, therefore the requester is not entitled to reimbursement for this disputed service.

2. The requester is seeking additional reimbursement for therapy service codes 97110-GP x 6 units and 97112-GP x 2 units, rendered on July 12, 2022.

Review of submitted documentation finds that the therapy services in dispute, per EOB dated 8/29/2022, initially reduced payment for lack of documentation of time spent and number of units billed. The reduced payment decision was maintained upon reconsideration.

CPT Code 97110 is described as "Therapy procedure using exercise to develop strength, endurance, range of motion and flexibility, *each 15 minutes*."

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."

Review of medical record submitted finds documentation of 85 minutes spent on therapy exercises, CPT 97110-GP and 25 minutes spent on neuromuscular therapy activities, CPT 97112-GP.

Medicare Claims Processing Manual Chapter 5 - Part B Outpatient Rehabilitation, which can be found at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf 20.2 - Reporting of Service Units With HCPCS, Part C., provides a chart: Counting Minutes for Timed Codes in 15 Minute Units. Accordingly, the division finds that the requester billed the appropriate number of units for services CPT codes 97110-GP and 97112-GP rendered on July 12, 2022.

The insurance carrier's denial is not supported. The disputed service will be reviewed per applicable fee guideline.

Per 28 TAC §134.203 (b)(1), parties are required to apply Medicare payment policies, including its coding, billing, correct coding initiatives (CCI) edits, modifiers, and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules to workers' compensation coding, billing, reporting, and reimbursement of professional medical services.

Per [Medicare Claims Processing Manual (cms.gov)](), Chapter 5, 10.7, effective February 6, 2019:

Medicare applies a multiple procedure payment reduction (MPPR) to the practice expense (PE) payment of select therapy services. The reduction applies to the HCPCS codes contained on the list of "always therapy" services … Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure … Full payment is made for the unit or procedure with the highest PE payment … 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.

The MPPR Rate File that contains the payments for 2022 services is found at www.cms.gov/Medicare/Billing/TherapyServices/index.html.

To determine the maximum allowable reimbursement (MAR) the following formula is used:

(DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = MAR.

- MPPR rates are published by carrier and locality.
- The disputed date of services is July 12, 2022.
- The disputed services were rendered in zip code 75211, carrier 04412, locality 11.
- The Medicare participating amount for CPT code 97110 in 2022, at this locality is $30.51 for the first unit, and $23.41 for subsequent units.
- The Medicare participating amount for CPT code 97112 in 2022, at this locality is $35.48 for the first unit, and $26.78 for subsequent units.
- 97112, having the highest PE payment, will receive full payment for first unit; subsequent units of both 97112 and 97110 will receive the reduced MPPR rate per unit.
- The 2022 DWC Conversion Factor is 62.46
- The 2022 Medicare Conversion Factor is 34.6062
- Using the formula above, MAR for the first unit of 97112-GP is $64.04. MAR for the second (subsequent) unit of 97112-GP is $48.33.
- Using the formula above, MAR is $42.25/unit of 97110-GP = $253.51 MAR for 6 units of 97110-GP.
- The division finds the total MAR for disputed therapy codes rendered on July 12, 2022, is $365.88.
- The respondent paid $106.29.
- Additional reimbursement of $259.59 is recommended.

3. The requester is seeking reimbursement for disputed service 97750-GP. Per submitted medical bill, the date of service rendered was June 27, 2022. This service is described as Physical Performance Test or Measurement (e.g., musculoskeletal, functional capacity) with written report, each 15 minutes.

   Review of submitted documentation finds no report of 97750 services on disputed date, June 27, 2022. The submitted Physical Performance report is for a service date other than the one in dispute.

   The division finds that the requester is not entitled to reimbursement for 97750-GP rendered on June 27, 2022.

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 Division finds the requester has established that additional reimbursement is due for therapy services 97110-GP and 97112-GP rendered on July 12, 2022.

ORDER

Under Texas Labor Code §§413.031, the Division has determined the requestor is entitled to additional reimbursement for the disputed therapy services rendered on July 12, 2022.

It is ordered that Indemnity Insurance Co. of North America must remit to Peak Integrated Healthcare $259.59 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

______________________	______________________	May 12, 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.