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**
DALLAS DOCTOR'S PROFESSIONAL

**Respondent Name**
PLANO ISD

**MFDR Tracking Number**
M4-23-0910-01

**Carrier's Austin Representative**
Box Number 19

**DWC Date Received**
December 21, 2022

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| January 6, 2021 through December 15, 2021 | 99212, 99080-73, 99442, 99213, and 99203 | $2,606.43 | $0.00 |
| January 13, 2022 through June 8, 2022 | 99212, 99080-73, 99213, 99368, 99199, 97140, 97112, 97116, 97530, and 97110 | $2,366.80 | $1,465.96 |
| | **Total** | $4,973.23 | $1,465.96 |

## Requestor's Position

"I am including all certified cards signed for all dates of services starting 1/6/2021 and ending 12/15/2001. DOS 5/20/22, 5/26/22, 6/1/22, 6/3/22, 6/8/22 were denied due to pre-treatment exceeded. (Please see enclosed pre-auth letter). None of our services have been paid."

**Amount in Dispute:** $4,973.23

## Respondent's Position

"The list of services in question date from 1/6/2021-6/8/2022. Multiple bills have been received and either paid or denied, mostly for timely filing, but in some instances for lack of medical records. The provider has sent multiple certified mail receipts of which it appears the medical bills related to those certified receipts have been processed. Attached are copies of all bills related to this complaint along with EOB's. Some of the dates of service cannot be located as ever being received..."

**Submitted by:** Claims Administrative Services, Inc., (CAS)

# 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 §134.600 sets out the Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.

Denial Reasons

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

- 29 – Time limit for filing has expired.
- 719 – Per Rule 133.20, a medical bill shall not be submitted later than the 95th day after the date of service.
- 720 – Preauthorization was approved for a maximum of 4 units per session
- 721 – Per rule 134.600 of the Texas administrative code, this procedure requires preauthorization, preauthorization not obtained.
- 197 – Precertification notification/authorization/pre-treatment absent.
- 198 – Precertification notification/authorization/pre-treatment exceeded.
- 720 – Preauthorization was approved for a maximum of 4 units per session. Units billed exceed preauthorization amount for date of service.

Issues

1. Did the requestor waive the right to medical fee dispute resolution for dates of service January 6, 2021 through December 15, 2021?
2. Did the requestor submit EOBs for dates of service May 10, 2022 and May 18, 2022?
3. What is the description of disputed CPT codes?
4. Is the insurance carrier's denial due to lack of preauthorization supported for CPT codes 99212, and 99080 rendered on January 13, 2022, and CPT code 99213 rendered on April 8, 2022?
5. Is the insurance carrier's denial for lack of preauthorization supported for services rendered on May 20, 2022 through June 8, 2022?
6. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for medical services rendered on January 6, 2021 through December 15, 2021. 28 TAC §133.307 (c) (1) states in pertinent part, "Timeliness. A requestor must timely file the request with the division or waive the right to MFDR. The division will deem a request to be filed on the date the division receives the request. A decision by the division that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

   28 TAC §133.307 (c) (1) (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute."

   The dates of the service in dispute are January 6, 2021 through December 15, 2021. The request for medical fee dispute resolution was received by the Division on December 21, 2022. This date is later than one year after the date(s) of service in dispute.

   Review of the submitted documentation finds that the disputed services do not involve issues identified in 28 TAC §133.307 (c) (1) (B). The Division concludes that the requestor has failed to timely file dates of service January 6, 2021 through December 15, 2021 with the Division; consequently, the requestor has waived the right to medical fee dispute resolution for dates of service, January 6, 2021 through December 15, 2021.

   The DWC finds that dates of service January 13, 2022 through June 8, 2022 were submitted timely and eligible for review.

2. The requestor seeks reimbursement for CPT Code 99368, rendered on May 10, 2022 and CPT Code 99199 rendered on May 18, 2022.

   Per 28 TAC §133.307 states, " (c) Requests. Requests for MFDR must be legible and filed in the form and manner prescribed by the division. . . (2) Health Care Provider or Pharmacy Processing Agent Request. The requestor must send the request to the division in the form and manner prescribed by the division by any mail service, personal delivery, or electronic transmission as described in §102.5 of this title. The request must include. . . (K) each explanation of benefits or e-remittance (collectively "EOB") related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB. . ."

   Review of the submitted documentation finds that the requestor did not submit convincing documentation of the insurance carrier's receipt of the request for an EOB, prior to the filing of the MDR. The DWC finds that CPT Code 99368, rendered on May 10, 2022 and CPT Code 99199 rendered on May 18, 2022 is not eligible for MDR review.

3. The requestor seeks reimbursement for CPT Codes 99212, 99080-73, 99213, 97140, 97112, 97116, 97530, and 97110, rendered on January 13, 2022, April 8, 2022, and May 20, 2022 through June 8, 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 99212 description "Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, **10**-**19** minutes of total time is spent on the date of the encounter."
   - CPT Code 99080-73 description, "Work Status Report."
   - CPT Code 99213 description, "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 97140 description, "Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each **15** minutes."
   - CPT Code 97112 description, "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 97116 description, "Therapeutic procedure, 1 or more areas, each **15** minutes; gait training (includes stair climbing)."
   - CPT Code 97110 description, "Therapeutic procedure, 1 or more areas, each **15** minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility."
   - CPT Code 97530 description, "Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each **15** minutes."
   - Modifier – GP description, "Services delivered under an outpatient physical therapy plan of care."

4. The requestor seeks reimbursement for CPT codes 99212, and 99080 rendered on January 13, 2022, and CPT code 99213 rendered on April 8, 2022. The insurance carrier denied the disputed services due to lack of preauthorization.

   28 TAC §134.600 does not require preauthorization for E&M and DWC-73 reports. As a result, the insurance carrier's denial reason is not supported, the requestor is entitled to reimbursement for the disputed services.

   The DWC finds that 28 TAC §134.203 applies to the billing and reimbursement of CPT Codes 99212, 99213.

   A review of the medical documentation for 99212 and 99213 finds that the requestor documented and billed for CPT codes 99212 and, 99213 and as a result, the requestor is entitled to reimbursement.

   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 Codes 99212 and 99213 were 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 75220; the Medicare locality is "Dallas."

   The Medicare Participating amount for CPT code 99212 at this locality is $57.70.
   - Using the above formula, the DWC finds the MAR is $104.17.
   - The respondent paid $0.00.
   - The requestor seeks $104.14
   - The requestor is due $104.14 for date of service January 13, 2022.

   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.
   - The requestor seeks $167.22.
   - The requestor is due $167.22 for date of service April 8, 2022.

The DWC finds that the requestor is due a total amount of $271.36 for CPT Codes 99212 and 99213, rendered on January 13, 2022, and April 8, 2022.

The DWC finds that 28 TAC §129.5 applies to billing and reimbursement of CPT code 99080-73 rendered on January 13, 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 $15.00. 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 requestor completed the DWC-73 in accordance with 28 TAC §129.5; therefore, reimbursement of $15.00 is recommended for the report rendered on January 13, 2022

5. The insurance carrier denied disputed dates of service May 20, 2022 through June 8, 2022 due preauthorization not obtained.

   The requestor in support of their position, submitted a copy of a preauthorization letter dated May 19, 2022, issued by RM Review Med, UR #899392. The preauthorization determination letter authorized 12 additional sessions of therapy to be completed May 19, 2022 through July 18, 2022."

The DWC finds the following:

| Date of Service | CPT Code | Number of Units Billed | Number of Units Preauth | Amount Sought | Amount Paid | Amount Recommended |
|---|---|---|---|---|---|---|
| 5/20/22 | 97140 | 1 | 1 | $50.59 | $0.00 | 1 unit |
| 5/20/22 | 97112 | 1 | 0 | $64.04 | $0.00 | 0 units |
| 5/20/22 | 97116 | 2 | 1 | $110.14 | $0.00 | 1 unit |
| 5/20/22 | 97110 | 2 | 4 | $110.14 | $0.00 | 2 units |
| 5/20/22 | 97530 | 1 | 1 | $69.81 | $0.00 | 1 unit |
| 5/26/22 | 97140 | 1 | 1 | $50.59 | $0.00 | 1 unit |
| 5/26/22 | 97110 | 2 | 4 | $110.14 | $0.00 | 2 units |
| 5/26/22 | 97116 | 2 | 1 | $110.14 | $0.00 | 1 unit |
| 5/26/22 | 97530 | 1 | 1 | $69.81 | $0.00 | 1 unit |
| 6/1/22 | 97140 | 1 | 1 | $50.59 | $0.00 | 1 unit |
| 6/1/22 | 97110 | 2 | 4 | $110.14 | $0.00 | 2 units |
| 6/1/22 | 97116 | 2 | 1 | $110.14 | $0.00 | 1 unit |
| 6/1/22 | 97530 | 1 | 1 | $69.81 | $0.00 | 1 unit |
| 6/3/22 | 97140 | 1 | 1 | $50.59 | $0.00 | 1 unit |
| 6/3/22 | 97110 | 2 | 4 | $110.14 | $0.00 | 2 units |
| 6/3/22 | 97116 | 2 | 1 | $110.14 | $0.00 | 1 unit |
| 6/3/22 | 97530 | 1 | 1 | $69.81 | $0.00 | 1 unit |
| 6/8/22 | 97140 | 1 | 1 | $50.59 | $0.00 | 1 unit |
| 6/8/22 | 97110 | 2 | 4 | $110.14 | $0.00 | 2 units |
| 6/8/22 | 97116 | 2 | 1 | $110.14 | $0.00 | 1 unit |
| 6/8/22 | 97530 | 1 | 1 | $69.81 | $0.00 | 1 unit |
| Total | | 31 | 35 | | $0.00 | 25 units |

The requestor seeks reimbursement for CPT Codes 97140, 97110, 97116, 97112, and 97530. A review of the preauthorization letter supports that CPT code 97112 was not included in the preauthorization letter. As a result, the preauthorization denial for CPT Code 97112 is supported and the requestor is not entitled to reimbursement for this code. The remaining codes were preauthorized, as a result the preauthorization denial is not supported and the disputed CPT codes are reviewed pursuant to the applicable rules and guidelines.

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 97140, 97116, 97110, 97112, and 97530 are subject to the MPPR policy.

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

| CPT Code | Practice Expense | Medicare Policy |
|---|---|---|
| 97140 | 0.35 | |
| 97116 | 0.40 | |
| 97110 | 0.40 | |
| 97112 | 0.49 | |
| 97530 | 0.64 | Highest PE |

As shown above CPT Code 97530 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. 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.

- MPPR rates are published by carrier and locality.
- The services were provided in Dallas, TX.
- CPT Codes 97140, 97116, 97110, and 97530

| CPT Code | Medicare Fee Schedule (1st unit) | MPPR for subsequent units |
|---|---|---|
| 97140 | | $21.81 |
| 97116 | | $23.41 |
| 97110 | | $23.41 |
| 97530 | $38.68 | |

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

The disputed services were 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 75220; the Medicare locality is "Dallas."

The Medicare Participating amount for CPT code 97140 at this locality is $21.81.

- Using the above formula, the DWC finds the MAR is $39.36 for one unit x 5 dates of service for a total reimbursement of $196.80.
- The respondent paid $0.00.
- The requestor is due a total of $196.80 for dates of service, May 20, 2022, May 26, 2022, June 1, 2022, June 3, 2022, and June 8, 2022.

The Medicare Participating amount for CPT code 97116 at this locality is $23.41.

- Using the above formula, the DWC finds the MAR is $42.25 for one unit x 5 dates of service for a total reimbursement of $211.25.
- The respondent paid $0.00.
- The requestor is due a total of $211.25 for dates of service, May 20, 2022, May 26, 2022, June 1, 2022, June 3, 2022, and June 8, 2022.

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

- Using the above formula, the DWC finds the MAR is $42.25/ unit x 2 units = $84.50 x 5 dates of service for a total reimbursement of $422.50.
- The respondent paid $0.00.
- The requestor is due a total of $422.50 for dates of service, May 20, 2022, May 26, 2022, June 1, 2022, June 3, 2022, and June 8, 2022.

The Medicare Participating amount for CPT code 97530 at this locality is $38.68.

- Using the above formula, the DWC finds the MAR is $69.81 for one unit x 5 dates of service for a total reimbursement of $349.05.
- The respondent paid $0.00.
- The requestor is due a total of $349.05 for dates of service, May 20, 2022, May 26, 2022, June 1, 2022, June 3, 2022, and June 8, 2022.

6. The DWC concludes that the requestor is entitled to reimbursement in the amount of $1,465.96. As a result, 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 $1,465.96.

## 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 $1,465.96 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

**Authorized Signature**

| | | |
|---|---|---|
| | | November 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.