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
Kamla Knight, DC

Respondent Name
Liberty Mutual Insurance Corporation

MFDR Tracking Number
M4-23-1115-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
January 11, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 10, 2022	G0283-59, 97110-59, 97112-59	$240.00	$0.00
January 10, 2022	99204-25	$250.00	$0.00
January 11, 2022	99080	$75.00	$0.00
January 12, 2022	G0283-59, 97110-59, 97112-59, 97012-59	$390.00	$0.00
January 14, 2022	97110-59, 97112-59, G0283-59, 97012-59	$390.00	$0.00
January 17, 2022	97110-59, 97012-59, G0283-59, 97112-59	$390.00	$0.00
January 19 - February 16, 2022	97110-59, 97012-59, G0283-59, 97112-59	$1950.00	$0.00
January 31 – March 30, 2022	97110-59, 97112-59, 97012, G0283	$2565.00	$0.00
January 26, 2022	97110-59, 97112-59, 97012, G0283-59	$315.00	$0.00
February 2, 2022	97110-59, 97112-59, E0730, 97012, G0283	$785.00	$0.00
March 7, 2022	97110-59, 97112-59, 97012, 97530-59, G0283	$360.00	$0.00
March 23, 2022	97110-59, 97112-59, 97012, G0283-59	$315.00	$0.00
April 11, 2023 [sic]	97112-59, G0283, 99214-25, 9710 [sic] -59	$335.00	$0.00
April 27, 2022	97110-59, 97112-59, 97530-59, G0283	$285.00	$0.00
	Total	$8325.00 [sic] $8645.00	$0.00

Requestor's Position

"I have made the necessary corrections to my bill with modifiers and CPT codes and resubmitted to LM as of 11/7/2022. I talked to Jarrod Roof who once again told me there is nothing he can do for me."

Amount in Dispute: $8645.00

Respondent's Position

"The provider resubmitted a bill for these DOS on 8/19/2022 and included additional DOS 1/17/2022 to 4/27/2022. At that time, the Case Specialist approved payment for these DOS although the provider submitted them past the 95-day timely filing rule and as the Case Manager gave retro-active approval for this out of network treatment for these DOS... The lines with the Therapy codes have been re-reviewed and are denied correctly as the provider did not bill with the needed Modifiers for those services… A request for reconsideration with the needed modifiers has not been submitted by the provider."

Response submitted by: Liberty Mutual

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 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out requirements for billing and coding of professional claims.
3. 28 TAC §133.20 sets out the requirements for timely submission of medical claims.
4. 28 TAC §129.5 details the requirements of work status reports.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

Explanation of benefits dated July 13, 2022.

- 4271 – Per Tx Labor Code Sec. 408.027, providers must submit bills to payors within 95 days of the date of service.
- 246 – This procedure is inappropriately billed. It should only be billed in conjunction with appropriate required code.

- 10 – The billed service requires the use of a modifier code.
- 242 – According to the fee schedule, this charge is not covered.
- 296- Service exceeds maximum reimbursement guidelines.

Explanation of benefits dated July 15, 2022.

- U301 – This item has been reviewed on a previously submitted bill, or is currently in process. Notification of decision has been previously provided or will be issued upon completion of our review.

Explanation of benefits dated August 10, 2022.

- 906 – In accordance with clinical based coding edits (National correct coding initiative/outpatient code editor), component code of comprehensive medicine, evaluation and management services procedure (90000 – 99999) has been disallowed.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. Original payment decision is being maintained. Upon review, I was determined that this claim was processed properly.
- 582 – Based on Medicare schedule, status indicates this code is either an invalid or delete CPT/HCPCS code. Medicare uses another code for reporting of, and payment for, this code. Please re-submit the appropriate code to ensure accurate processing.
- 242 – According to the fee schedule, this charge is not covered.

Explanation of benefits dated September 6, 2022.

- U301 – This item has been reviewed on a previously submitted bill, or is currently in process. Notification of decision has been previously provided or will be issued upon completion of our review.
- 10 – The billed service requires the use of a modifier code.
- 296 – Service exceeds maximum reimbursement guidelines.
- 876 – Fee schedule amount is equal to the charge.
- 582 – Based on Medicare schedule, status indicates this code is either an invalid or deleted CPT/HCPCS code. Medicare uses another code for reporting of, and payment for, this code. Please re-submit the appropriate code to ensure accurate processing,
- 906 – In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient code editor), component code of comprehensive medicine, evaluation and management services procedure (90000-99999) has been disallowed.
- 309 – The charge for this procedure exceeds the fee schedule allowance.

Explanation of benefits dated November 30, 2022.

- 906 – In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient code editor), Component code of comprehensive medicine, evaluation and management services procedure (90000-99999) has been disallowed.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 242 – According to the fee schedule, this charge is not covered.
- X598 – Claim has been re-evaluated based on additional documentation submitted; no additional payment due.
- 296 – Service exceeds maximum reimbursement guidelines.
- 876 – Fee Schedule amount is equal to the charge.
- 10 – The billed service requires a modifier.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 4 – The procedure code is inconsistent with the modifier used.
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.

Issues

1. Did the insurance carrier maintain a denial for 95-day timely filing?
2. Is CPT code 99204-25 separately payable?
3. Did the requestor append the appropriate modifier when billing for physical therapy services?
4. What modifier is required when billing for a work status report?
5. Is the requestor entitled to reimbursement for the DME charge?
6. Is the requestor entitled to reimbursement for the services in dispute?

Findings

1. The requestor is seeking additional reimbursement for professional services rendered in their office for dates of service beginning on January 10, 2022 through April 27, 2022. The insurance carrier submitted in their position statement, "The provider resubmitted a bill for these DOS (DOS 01/10/2022 to 01/14/2022) and included additional DOS 1/17/2022 to 4/27/2022. At that time, the Case Specialist approved payment for these DOS although the provider submitted them past the 95-day timely filing rule and as the Case Manager gave retro-active approval…"

   The DWC finds that the denials made for 95-day timely filing were not maintained. The disputed services are therefore reviewed pursuant to the applicable rules and guidelines.

2. The requestor is seeking reimbursement of Code 99204-25 for date of service January 10, 2022. The insurance carrier denied this claim line based on NCCI edits on August 10, 2022.

   DWC Rule 28 TAC §134.203 (b) (1) states in pertinent parts, for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers…

   The requestor billed for CPT codes 98941, 98943, G0283-59, G0283-59, 97710-59 and 97112-59 on January 10, 2022. Review of the applicable NCCI edits found on the submitted date of service Code 99204-25 has a CCI edit with codes 98941 and 98943 billed on the same day. The requestor appended modifier -25 to identify a "Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service."

   Review of the medical documentation does not support the use of modifier -25. As a result, the insurance carrier's denial is supported and payment cannot be recommended.

3. The requestor's DWC60 and corrected bill dated November 7, 2022 indicates the following codes, modifier, and dates of service.

   - 97110-59. January 10, 12, 14, 17, 19, 21, 24, 26, 28, 31. February 2, 14,16, 18, 23, 25. March 7, 11,16, 23, 30. April 11, 27, 2022.
   - 97012-59. January 12, 14, 17, 19, 21, 24, 26, 28, 31. February 2, 14, 16, 18, 23, 25. March 7, 11,16, 23, 30. April 11, 27, 2022.
   - G0283-59. January 10, 12, 14, 17, 19, 21, 24, 26, 28, 31. February 2, 14, 16, 18, 23, 25. March 7, 11, 16, 23, 30. April 11, 27, 2022.
   - 97112-59. January 10, 12, 14, 17, 19, 21, 24, 26, 28, 31. February 2, 14, 16, 18, 23, 25. March 7, 11, 16, 23, 30. April 11, 27, 2022.
   - 97530-59. March 7, 2022.

   DWC Rule 28 TAC §134.203 (b) (1) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services. Texas workers' compensation system participants shall apply the Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers…"

   The applicable Medicare coding policy pertaining to physical therapy services is found at www.cms.gov, Claims Processing Manual, Chapter 5, Section 20.1 – Discipline Specific Outpatient Rehabilitation Modifiers – All claims, states in pertinent part,

"The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered:

- *GN Services delivered under an outpatient speech-language pathology plan of care;*
- *GO Services delivered under an outpatient occupational therapy plan of care; or,*
- *GP Services delivered under an outpatient physical therapy plan of care.*

This is applicable to all claims from physicians, nonphysician practitioners (NPPs), PTPPs, OTPPs, SLPPs, CORFs, OPTs, hospitals, SNFs, and any others billing for physical therapy, speech-language pathology, or occupational therapy services as noted on the applicable code list in §20 of this chapter."

Review of the submitted medical bill(s) in dispute found the required modifier was not appended to the disputed physical therapy services. The DWC finds that the requestor did not meet the requirement of Rule 28 TAC §134.203 (b) (1), as a result, reimbursement cannot be recommended.

4. Review of the submitted DWC60 found the following codes in dispute.

   Code 99080 for date of service January 11, 2022 was denied as, 242 – According to fee schedule, this charge is not covered and 193 – Original payment decision is being maintained.

   DWC Rule 28 TAC §129.5(j)(1) details the Division's requirements for billing a work status report. The rule states;

   "Notwithstanding any other provision of this title, a doctor, delegated physician assistant, or delegated advanced practice registered nurse may bill for, and an insurance 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 insurance carrier, its agent, or the employer through its insurance carrier asks for an extra copy. The amount of reimbursement shall be $15. A doctor, delegated physician assistant, or delegated advanced practice registered nurse 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, delegated physician assistants, or delegated advanced practice registered nurses are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors, delegated physician assistants, or delegated advanced practice registered nurses 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, delegated physician assistant, or delegated advanced practice registered nurse is billing for a report required under subsections (e)(1), (e)(2), and (g) of this section…"

   The original and revised medical bill did not contain the divisions' mandatory billing modifier of -73 when billing for a work status report. The denial made by the insurance company is supported. The recommended payment is $0.00.

5. Code E0730, date of service February 2, 2022. The insurance carrier reduced the billed amount with Remark code 309 – The charge for this procedure exceeds the fee schedule allowance.

   DWC Rule 28 TAC §134.203 (d) states in pertinent part, the MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A,E,J,K, and L shall be determined as 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule.

   Review of the applicable fee guideline found the allowable is $153.82 x 125% = $192.28. The insurance carrier paid $192.28 on September 6, 2022. No additional payment is due.

6. The DWC finds that the information contained in the dispute did not support payment for the disputed services. As a result, $0.00 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.

DWC finds the requester has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 15, 2023 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.