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
Texas Mutual Insurance Company

MFDR Tracking Number
M4-23-1344-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
February 8, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 9, 2022	Outpatient Professional Medical Services 99213; 99080-73; 97110-GP; 97112-GP	$274.84	$180.04

Requestor's Position

This is a necessary office visit for patients care ... Evaluation and management outpatient visits to the offices of medical doctors play a critical role in the propre diagnosis and return to function of an injured worker, and they should be encouraged. **The current TDI statutes and regulations require an injured worker to be present to sign a DWC work status form 73** ... In order to satisfy the TDI requirements, an office visit is billed for the required time taken by the treating physician to assess the injured worker's return to work status.

Amount in Dispute: $274.84

Respondent's Position

Peak Integrated Healthcare billed the office visit with CPT code 99213 whithout modifier 25 on the same date of service and bill as physical therapy services. Correct billing guidelines directs health care providers that E/M services may be reported only if the patient's condition requires a significant separately identifiable E/M service as indicated by modifier 25. The physical therapy services in question were paid per fee guidelines as shown on the attached EOB.

Response Submitted by: Texas Mutual Insurance Company

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 §129.5 sets out the requirements for work status reports.

2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

3. 28 TAC §133.203 sets out the fee guidelines for professional medical services.

Denial Reasons

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

- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- CAC-131 – Claim specific negotiated discount.
- CAC-150 – Payer deems the information submitted does not support this level of service
- 248 – DWC-73 in excess of the filing requirements; no change in work status and/or restrictions; reimbursement denied per rule 129.5
- 650 – Allowance is reduced per the multiple procedure payment reduction for selected therapy services.
- 864 – E/M services may be reported only if the patient's condition requires a significant separately identifiable E/M service.
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
- CAC-18 – Exact duplicate claim/service
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 878 – Appeal (request for reconsideration) previously processed. Refer to Rule 133.250(h)

Issues

1. Is Texas Mutual Insurance Company's denial of payment for CPT code 99213 based on level of service supported?

2. Is Texas Mutual Insurance Company's denial of payment for CPT code 99213 based on

3. Is Texas Mutual Insurance Company's denial of payment for CPT code 99080 supported?

4. Is Peak Integrated Healthcare entitled to additional reimbursement for the services in question?

Findings

1. Peak Integrated Healthcare is seeking additional reimbursement for physical therapy services (97110-GP and 97112-GP), an evaluation and management examination (99213), and a work status form (99080-73). Texas Mutual Insurance Company denied payment, in part, stating that the "payer deems the information submitted does not support this level of service."

   CPT code 99213 is defined as an

   > 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.

   Review of available documentation finds that the level of service for CPT code 99213 was met. This denial reason is not supported.

2. Texas Mutual Insurance Company also denied payment for CPT code 99213 stating that, "E/M services may be reported only if the patient's condition requires a significant separately identifiable E/M service."

   In its position statement, the insurance carrier also stated,

   > Peak Integrated Healthcare billed the office visit with CPT code 99213 whithout modifier 25 on the same date of service and bill as physical therapy services. Correct billing guidelines directs health care providers that E/M services may be reported only if the patient's condition requires a significant separately identifiable E/M service as indicated by modifier 25.

   28 TAC §133.203 (b) 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 payment policies do not contain any edits for the services in question that would prevent them from being reported on the same date of service. A modifier is not required for this service. DWC finds that this denial reason is not supported.

3. Texas Mutual Insurance Company also denied payment for CPT code 99080-73, which represents the Texas Workers' Compensation Work Status Report, stating, "DWC-73 in excess of the filing requirements; no change in work status and/or restrictions; reimbursement denied

per rule 129.5."

28 TAC §129.5 (e) states:

> The doctor, delegated physician assistant, or delegated advanced practice registered nurse shall file the Work Status Report:
> (1) after the initial examination of the injured employee, regardless of the injured employee's work status;
> (2) when the injured employee experiences a change in work status or a substantial change in activity restrictions; and
> (3) on the schedule requested by the insurance carrier, its agent, or the employer requesting the report through its insurance carrier, which shall not exceed one report every two weeks and which shall be based upon the doctor's, delegated physician assistant's, or delegated advanced practice registered nurse's scheduled appointments with the injured employee.

Subsection (g) goes on to say:

> In addition to the requirements under subsection (e) of this section, the treating doctor, delegated physician assistant, or delegated advanced practice registered nurse shall file the Work Status Report with the insurance carrier, employer, and injured employee within seven days of the day of receipt of:
> (1) functional job descriptions from the employer listing available modified duty positions that the employer is able to offer the injured employee as provided by §129.6(a) of this title (relating to Bona Fide Offers of Employment); or
> (2) a required medical examination doctor's Work Status Report that indicates that the injured employee can return to work with or without restrictions.

No evidence was provided to prove that the Work Status Report in question met the requirements of 28 TAC §129.5 (e) or (g). Therefore, the insurance carrier's denial reason for this service is supported. No reimbursement is recommended.

4. Because the insurance carrier failed to support its denial reasons for CPT code 99213, Peak Integrated Healthcare is entitled to reimbursement for this service. DWC will also review payment amounts for CPT codes 97110-GP and 97112-GP.

28 TAC §133.203 (c) states:

> To determine the [maximum allowable reimbursement] 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 …
> (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 Participating Amount.

- The DWC conversion factor for 2022 is 62.46.
- The Medicare conversion factor for 2022 is 34.6062.
- Per the submitted medical bills, the service was rendered in zip code 75211 which is in Medicare locality 0441211.

The Medicare participating amount for CPT code 99213 for 2022, locality 0441211 is $92.65. The MAR is calculated as follows: (62.46/34.6062) x $95.65 = **$167.22**.

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.

CPT codes 97110 and 97112 are classified as "always therapy" in the 2022 Therapy Code List and Dispositions found at Annual Therapy Update | CMS and has a value of "5" on the MFSD. Therefore, the MPPR applies to the reimbursement of these codes.

The Medicare participating amount for CPT code 97110 is $30.51 for the first unit and $23.41 for subsequent units. The MAR is calculated as follows:

- (62.46/34.6062) x $30.51 = $55.07 for the first unit.
- (62.46/34.6062) x $23.41 = $42.25 for each subsequent unit.
- The total MAR for six units is **$266.33**.

The Medicare participating amount for CPT code 99212 is $35.48 for the first unit and $26.78 for subsequent units. The MAR is calculated as follows:

- (62.46/34.6062) x $35.48 = $64.04 for the first unit.
- (62.46/34.6062) x $26.78 = $48.33 for each subsequent unit.

- The total MAR for two units is **$112.37**.

The total allowable reimbursement for the services in dispute is $545.92. The insurance carrier paid $365.88. An additional $180.04 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 established that additional reimbursement of $180.04 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Texas Mutual Insurance Company must remit to Peak Integrated Healthcare $180.04 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		April 28, 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.