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
PEAK INTEGRATED HEALTHCARE

Respondent Name
NORTH RIVER INSURANCE COMPANY

MFDR Tracking Number
M4-23-1403-01

Carrier's Austin Representative
Box Number 53

DWC Date Received
February 15, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 10, 2022 through November 18, 2022	97110-GP, 97112-GP, 97750-GP, E0730-NU, and 99361-W1	$1,265.81	$0.00
	Total	$1,265.81	$0.00

Requestor's Position

"This patient had a CONTESTED CASE HEARING on October 10, 2022 and it was determined that the patient sustained a compensable injury… I have included a copy of the decision and order. Per Rule 410.208(a)(b), a carrier is court ordered to PAY IN FULL."
Amount in Dispute: $1,265.81

Respondent's Position

"With respect to date of service 5/10/22, Carrier paid $458.50 with heck number C15155239 on 6/10/22. See page 59 for copy of the EOB indicating 458.50 will be paid. For date of service 5/19/22, provider failed to submit its bill to Carrier within 95 days of the date of service. Therefore, Carrier properly denied the bill. See page 60. Provider attaches no proof of timely submission. For date of service 9/22/22, Carrier denied the bill because this was a duplicate service. See page 61. This is a tens unit purchase, not rental. For date of service 11/18/2, Carrier properly denied the bill because it exceeds the fee schedule allowance, and the services are not authorized pursuant to Carrier's extent of injury dispute. See pages 63. For the 11/18/22 date of service, the services were not provided for the accepted compensable injury. This date of service must be dismissed pursuant to Rule 133.305(b) and 133.307 (f)(3)(C) because there is an unresolved extent of injury issue. Provider billed under diagnosis… On September 7, 2022, Carrier

filed a PLN11 extent of injury dispute, disputing that the current diagnoses were related to the compensable injury dispute, disputing that the current diagnoses were related to the compensable injury. See pages 64-76. Carrier specifically disputed the compensable injury… and the remaining conditions were listed on the PLN11 dispute."

Response Submitted by: Hoffman Kelley Lopez, LLP

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. TLC §408.027 sets out the rules for timely submission of claims by health care providers.
6. TLC §408.0272 provides for certain exceptions to untimely submission of a medical bill.
7. 28 TAC §134.220, effective July 7, 2016, provides the medical fee guidelines for case management service.

Denial Reasons

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

CPT codes: 97110-GP, 97112-GP, E0730-NU

- 18 – Exact duplicate claim/service.
- 247 – A payment or denial has already been recommended for this service.

CPT code 97750-GP

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

CPT code 99361-W1

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 5589 – Services not authorized.
- W3 – Bill is a reconsideration or appeal
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional

allowance is warranted.

- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. What is the timely filing deadline applicable to CPT code 97750-GP rendered on May 19, 2022?
2. Did the insurance carrier issue payments for CPT codes 97110-GP, 97112-GP, rendered on May 10, 2022?
3. Is the requestor entitled to reimbursement for HCPCS code E0730-NU rendered on September 22, 2022?
4. Is the Requestor entitled to reimbursement for CPT code 99361-W1?

Findings

1. The requestor seeks reimbursement for CPT codes 97750-GP rendered on May 19, 2022. The insurance carrier denied the disputed service with denial reduction codes;
    - 29 – The time limit for filing has expired.
    - 4271 – Per TX labor code sec. 408.027, provider must submit bills to payors within 95 days of the date of service.

    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 insufficient documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Therefore, pursuant to TLC §408.027(a), the requestor has forfeited the right to reimbursement for CPT code 97750-GP rendered on May 19, 2022, due to untimely submission of the medical bill for the disputed services.

2. The requestor seeks reimbursement CPT codes 97110-GP, 97112-GP, rendered on May 10, 2022. The insurance carrier issued a payment and reduced the remaining charges with denial reduction codes;
    - 18 – Exact duplicate claim/service.
    - 247 – A payment or denial has already been recommended for this service.

    28 TAC §134.203(a)(5) states, "'Medicare payment policies' when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

    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 code 97112 has a PE RVU of 0.49, and CPT Code 97110 has a PE RVU of 0.40, as a result 97112 has the highest PE RVU, and therefore the first unit of 97112 is eligible for the full payment and the remaining units are subject to the MPPR.

CPT Code	PE RVU	Medicare Fee Schedule (first unit)	MPPR for subsequent units
97112	0.49	$35.48	$26.78
97110	0.40	N/A	$23.41

The DWC refers to 28 TAC §134.203, which 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).

- The 2022 DWC Conversion Factor is 62.46
- The 2022 Medicare Conversion Factor is 34.6062
- Per the medical bills, the services were rendered in zip code 75043; therefore, the Medicare locality is "Dallas."

The Medicare Participating amount for CPT code 97112 at this locality is $35.48 for the first unit and $26.78 for subsequent units.

- Using the above formula, the DWC finds the MAR is $64.04 x 1 unit and $48.33 x 1 unit for a total MAR of $112.37.
- The respondent paid $128.08.
- Additional reimbursement is not recommended.

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

- Using the above formula, the DWC finds the MAR is $42.25/unit x 6 units = MAR $253.51.
- The respondent paid $330.42.
- Additional reimbursement is not recommended.

The insurance paid a total of $458.50; the requestor is therefore not entitled to an additional payment.

3. The requestor seeks reimbursement for HCPCS code E0730-NU rendered on September 22, 2022. The insurance carrier denied the disputed service with denial reduction codes;
   - 18 – Exact duplicate claim/service.
   - 247 – A payment or denial has already been recommended for this service.

   The requestor billed HCPCS code E0730-NU on July 21, 2022 and September 22, 2022. The HCPCS code E0730 is defined as a Tens Unit. The -NU modifier identifies that the item was purchased and not a rental. The insurance carrier issued a payment amount of $192.23 for the Tens unit rendered on July 21, 2022. The requestor seeks reimbursement for a Tens Unit

purchase rendered on September 22, 2022. The insurance carrier denied date of service September 22, 0222 due to a duplicate claim and payment has already been recommended. The DWC finds that the TENS unit purchased on July 21, 2022 is the same DME item billed on September 22, 2022. Review of the documentation submitted by the requestor does not document why the injured employee required the same DME/Tens Unit in September 22, 2022, that previously purchased on July 21, 2022. The DWC finds that the insurance carrier's denial reasons are supported. The requestor is therefore not entitled to reimbursement for HCPCS code E0730-NU rendered on September 22, 2022.

4. The requestor seeks reimbursement in the amount of $113, for CPT code 99361-W1 rendered on November 18, 2022. The insurance carrier denied the disputed service based on denial reduction codes;
    - P12 – Workers' compensation jurisdictional fee schedule adjustment.
    - 309 – The charge for this procedure exceeds the fee schedule allowance.
    - 5589 – Services not authorized.
    - W3 – Bill is a reconsideration or appeal
    - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
    - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance is warranted.

The fee guidelines for disputed services 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 respondent's denial of payment for CPT code 99361-W1 is supported because the "Team Conference" report does not meet documentation requirements found in 28 TAC §134.220(1) and (2).

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 not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to reimbursement for the disputed services.

Authorized Signature

		May 8, 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 managing 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.