TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
VINCERA REHAB

Respondent Name
ACE AMERICAN INSURANCE COMPANY

MFDR Tracking Number
M4-23-2027-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
April 13, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 10, 2022	97110, 97112, 97016, 97535	$655.00	$0.00
	Total	$655.00	$0.00

Requestor's Position

"The claim is for the professional charges for physical therapy associated with the procedure performed by Dr. W. Meyers at the Vincera Surgery Center. Prior to the patient having surgery, Vincera reached out to the WC adjuster to verify coverage of the claim. Per the attached email chain, from the adjuster, Deborah Fields, our office was not advised a separate authorization was needed from the bill review company for the bills to be processed. We were advised that the patient was approved for 'the works' i.e., office visits, MRI, surgery, & physical therapy after surgery. There is no documentation written or verbal that a separate authorization is needed."
Amount in Dispute: $655.00

Respondent's Position

"…CorVel has since been provided with the correct claim number and determined the requestor has provided evidence of their due diligence in submitting the medical billing in question for date of service 08/10/22 with the necessary documentation of the service rendered. Therefore, reimbursement is warranted. An immediate re-audit has occurred that allows reimbursement and all accrued interest in accordance with the Act and division rules. A copy of the explanation of benefits is attached."
Response Submitted by: CorVel

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) §134.203 sets out the fee guideline for professional medical services.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

Denial Reasons

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

- 352 - Network disc not applicable to procedure billed.
- P12 - Workers' Compensation State Fee Schedule Adj.
- B13 - Payment for service may have been previously paid.
- W3 - Appeal/ Reconsideration.

Issues

1. Under what authority is the request for medical fee dispute resolution considered?
2. Did the Insurance Carrier issue payment for the disputed services rendered on August 10, 2022?
3. Does the Medicare, multiple procedure payment reduction (MPPR) apply to the disputed services?
4. Is the Requestor entitled to additional reimbursement?

Findings

1. The requestor is a health care provider that rendered the disputed services in Philadelphia, Pennsylvania to an injured employee with an existing Texas Workers' Compensation claim. The health care provider requested reconsideration from the insurance carrier and was dissatisfied with the insurance carrier's final action. The health care provider has requested medical fee dispute resolution under 28 TAC §133.307.

   Because the requestor has sought the administrative remedy outlined in 28 TAC §133.307 for resolution of this matter. The Division concludes that it has authority to decide the issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules

2. The requestor seeks reimbursement in the amount of $655.00 for CPT Codes 97110, 97112, 97016 and 97535 rendered on August 10, 2022. Review of the documentation submitted by the insurance carrier, supports that a payment in the amount of $427.27 was issued to the requestor for the disputed services. The DWC will now determine if the insurance carrier issued payments in accordance with 28 TAC §134.203.

3. 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."

   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 2021 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 found that the disputed CPT Code are subject to the MPPR policy.

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

4. 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).

   - 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 19112; therefore, the Medicare locality is "PA."

   - CPT Code 97535 has a practice expense RVU of 0.50 – Highest RVU 100% reimbursement.
   - The Medicare Participating amount for CPT code 97535 at this locality is $35.48.
   - Using the above formula, the DWC finds the MAR is $64.04.
   - The respondent paid $58.66.
   - Reimbursement of $0.00 is recommended

   - CPT Code 97110 has a practice expense RVU of 0.40 – 50% reimbursement.
   - The Medicare Participating amount for CPT code 97110 at this locality is $24.24.
   - Using the above formula, the DWC finds the MAR is $43.75 x 4 units $175.00.
   - The respondent paid $210.80.
   - Reimbursement of $0.00 is recommended.

   - CPT Code 97112 has a practice expense RVU of 0.49 – 50% reimbursement.
   - The Medicare Participating amount for CPT code 97112 at this locality is $27.70.
   - Using the above formula, the DWC finds the MAR is $50.00 2 units $99.99.
   - The respondent paid $122.38.
     Reimbursement of $0.00 is recommended.

   - CPT Code 97016 has a practice expense RVU of 0.16 – 50% reimbursement.
   - The Medicare Participating amount for CPT code 97016 at this locality is $9.78.
   - Using the above formula, the DWC finds the MAR is $17.65.
   - The respondent paid $21.15.
     Reimbursement of $0.00 is recommended.

   Review of the submitted documentation finds that the requestor is not entitled to additional reimbursement for the disputed CPT codes, 97110, 97112, 97016, and 97535.

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 of $0.00 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

		August 1, 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.