Division of Workers' Compensation

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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Peak Integrated Healthcare

Respondent Name
Birkshire Hathaway Homestate Insurance

MFDR Tracking Number
M4-23-2763-01

Carrier's Austin Representative
Box Number 12

DWC Date Received
June 28, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
04/19/2023	97110-GP	$115.62	$0.00
04/19/2023	97112-GP	$16.46	$0.00
04/20/2023	97110-GP	$115.62	$0.00
04/20/2023	97112-GP	$16.46	$0.00
04/25/2023	97110-GP	$115.62	$0.00
04/25/2023	97112-GP	$16.46	$0.00
04/26/2023	97110-GP	$115.62	$0.00
04/26/2023	97112-GP	$132.76	$0.00
	Total	$644.62	$0.00

Requestor's Position

"I have attached the authorization for these dates of service. We requested authorization for CPT codes 97110 and 97112 before scheduling treatment. The units are for 2 units of 97110 and 2 units of 97112. Please note you approved these 6 sessions of physical therapy Preauth #1100891."

Amount in Dispute: $644.62

Respondent's Position

"Berkshire Hathaway Homestate Company has agreed to pay the disputed amount of $87.96 for date of service 4/19/23. Based upon the attached UR determination #1100891 dated 4/11/23 only 2 visits of physical therapy were authorized for the lumbar and thoracic spine. We have

issued payment for the 2 authorized visits. Please see attached check EOR's for dates of service 4/18/23 & 4/19/23."

Response Submitted by: Berkshire Hathaway Homestate 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 (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 guidelines for specific treatments and services.

Denial Reasons

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

- M2(P12) – The usual treatment session provided in the home or office setting is 30 to 45 minutes. The medical necessity of services for an unusual length of time must be documented.
- 01(P12) – The charge for the procedure exceeds the amount indicated in the fee schedule.
- 4(P12) – Precertification / authorization exceeded.
- @G(W3) – No additional reimbursement allowed after review of appeal / reconsideration.
- 197 – The procedure or supply requires prior authorization.
- P12TX – Workers' compensation jurisdictional fee schedule adjustment.
- W3TX – Additional payment made on appeal / reconsideration.

Issues

1. Which disputed services have been previously reimbursed?
2. Is the Insurance Carrier's denial reason based on preauthorization supported?
3. Is the Requestor entitled to additional reimbursement?

Findings

1. The requestor seeks medical fee dispute resolution (MFDR) for CPT Codes 97710-GP and 97112-GP rendered on disputed dates of service April 19, 2023, through April 26, 2023.

   Review of submitted explanation of benefits (EOB) documents finds the following reimbursements have been previously paid:

- For date of service April 19, 2023, $116.30 was issued on May 18, 2023, for CPT 97112.
- For date of service April 19, 2023, $87.96 was issued on July 10, 2023, for CPT 97110.
- For date of service April 20, 2023, $116.30 was issued on May 16, 2023, for CPT 97112.
- For date of service April 25, 2023, $116.30 was issued on May 16, 2023, for CPT 97112.

The DWC finds that disputed dates of service April 19, 20 and 25, 2023 have received reimbursements in the total amount of $436.86.

2. The services in this dispute which have not been previously paid were denied based on preauthorization reasons. Specifically, the disputed services which have received $0.00 reimbursement and were denied based on preauthorization reasons are:

    - 97110 rendered on April 20, 2023
    - 97110 rendered on April 25, 2023
    - 97110 rendered on April 26, 2023
    - 97112 rendered on April 26, 2023

    28 TAC §134.600 which sets out preauthorization guidelines for specific treatments and services, states in pertinent part, "(p) Non-emergency health care requiring preauthorization includes: ... (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:

    (A) Level I code range for Physical Medicine and Rehabilitation, but limited to:
    (i) Modalities, both supervised and constant attendance;
    (ii) Therapeutic procedures, excluding work hardening and work conditioning;
    (iii) Orthotics/Prosthetics Management;
    (iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code;... "

    The CPT codes in dispute are described as follows:
    CPT code 97110 - "Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility."

    CPT Code 97712 – "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."

    In accordance with 28 TAC §134.600(p), the DWC finds that the disputed CPT codes, 97110 and 97112, require preauthorization.

    Review of submitted documents finds that per utilization review dated April 11, 2023, the therapeutic procedures in dispute were certified/preauthorized for a total of 2 units per each procedure to be rendered between April 10, 2023, and July 9, 2023. Review of submitted medical bills finds that the requestor billed for 8 units of 97110 and 8 units of 97112 between the dates of April 19, 2023, and April 26, 2023.

    The DWC finds that the insurance carrier's denial based on preauthorization is supported.

3. The requestor is seeking additional reimbursement in the amount of $644.62 for disputed dates of service April 19, 20, 25 and 26 of 2023. The DWC has established above that the therapeutic services in dispute were preauthorized for a total of 2 units each of CPT codes 97110 and 97112. Therefore, the DWC will adjudicate the maximum allowable reimbursement (MAR) for the number of units that were preauthorized.

   The fee guidelines applicable to the services in dispute are found at 28 Texas Administrative Code §134.203, which states in pertinent part, "(a)(5) '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.

   The MPPR Rate File that contains the payments for 2023 services is found at: www.cms.gov/Medicare/Billing/TherapyServices/index.html.

   The DWC finds that CPT Codes 97110 and 97112 are subject to the MPPR policy. The CPT code 97112 is found to have the highest PE/RVU of the therapeutic services billed on the disputed dates of service. Therefore, the first unit of CPT code 97112 will receive full payment

and the reduced PE payment will apply to all subsequent units of timed therapy codes performed on the same date of service.

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...”

- MPPR rates are published by carrier and locality.
- Per the medical bills, the services were rendered in zip code 75043; Medicare locality is 11, Dallas, TX.

- To determine the MAR the following formula is used:
  (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = MAR

- The 2023 DWC Conversion Factor is 64.83
- The 2023 Medicare Conversion Factor is 33.8872

- The Medicare Participating amount for CPT code 97112 at locality 11 in 2023, is $34.70 for the first unit and $26.09 for the second unit.
- Using the above formula, the DWC finds the MAR is $66.38 for the first unit and $49.91 for second unit. Therefore, the MAR for 97112 x 2 units = $116.29.

- The Medicare Participating MPPR amount for CPT code 97110 at locality 11 in 2023 is $22.99.
- Using the above formula, the DWC finds the MAR for 97110 x 2 units = $87.96.

- The DWC finds that the total MAR for the preauthorized 2 units of CPT code 97112 plus 2 units of CPT code 97110 is $204.25.
- The respondent paid a total of $348.90 for CPT code 97112 for disputed dates of service April 19, 20 and 25 of 2023.
- The respondent paid a total of $87.96 for CPT code 97110 for disputed date of service April 19, 2023.
- The DWC finds that the insurance carrier has paid a total amount of $436.86 for services in dispute. Therefore, no additional reimbursement 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 additional reimbursement is due.

Order

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

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 18, 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.