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
Zurich American Insurance Co.

MFDR Tracking Number
M4-23-3280-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 23, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 12, 2023	97110-GP	$82.98	$13.84
May 12, 2023	97112-GP	$132.76	$-16.47
May 16, 2023	99213	$174.71	$174.70
May 16, 2023	99080-73	$15.00	$0.00
May 16, 2023	97110-GP	$346.86	$277.72
May 16, 2023	97112-GP	$16.46	$99.83
May 16, 2023	99361-W1	$113.00	$0.00
May 19, 2023	97110-GP	$346.86	$277.72
May 19, 2023	97112-GP	$16.46	$-16.47
	Total	$1245.09	$810.87

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of their reconsideration with a hand written note dated August 23, 2023 that states, "Again we argue that these dates of service should be PAID IN FULL. Only the 5/9/23 date of service was paid accordingly."

Amount in Dispute: $1245.09

Respondent's Position

"Upon review of the billed services, payment was adjusted because the usual treatment session provided in the home or office setting is 30 to 45 minutes and the necessity of the services for an unusual length of time must be documented. Notably, the preauthorization notice did not authorize the extended length of time billed. Therefore, the bill was also reduced because the services provided exceeded the amount of services authorized. As such, the Carrier contends that the bills were reviewed in compliance with the contract and the DWC rules and the dispute should be dismissed."

Response Submitted by: Stone Loughlin Swanson

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 134.600 sets out the requirements of prior authorization.
3. 28 TAC 134.203 sets out the fee guidelines for professional medical services.
4. Texas Labor Code §413.014 details the requirements of retrospective review via utilization review

Denial Reasons

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

- 01 – The charge for the procedure exceeds the amount indicated in the fee schedule.
- APR V – The Provider's charges were reviewed with consideration of the Payer's UR/Pre-Authorization Decision(s) governing this Claimant.
- MZ – 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.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- WOCP – WorkCompEDI Scanning/Data Capture of Professional bill.
- OX – Payment for case management services requires documentation that the services

have been rendered in accordance with 134.202(c)(3).

- 151 – Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
- @F – Additional payment made on appeal/reconsideration.
- EXPA – Service exceeds Pre-Authorization approval. Please provide documentation and/or additional authorization for the service not included in the original documentation.
- N4 – Periodic evaluations of the patient's condition and response to treatment may be covered when medically necessary and if the judgement and skills of a professional provider are required.
- UY – The number of units billed for this procedure code exceeds the reasonable number usually provided in a given setting, as defined within the Medically Unlikely Edits (MUEs) which is published and maintained by the Centers for Medicare and Medicaid Services. The provider's charge was granted an allowance up to the MUE value.
- W3 – The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.

Issues

1. Are the insurance carrier's denials limiting units and time of session supported?
2. What rule is applicable to reimbursement?
3. Is the office visit, team conference and work status report for date of service May 16, 2023 payable?
4. Is requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for physical medicine services rendered in May of 2023. The insurance carrier denied the number of units and sessions based on the authorization exceeded, Medically Unlikely Edits and limits on the time of each session.

   Review of the Medata Review dated May 5, 2023 found Additional Physical Therapy x6 session (CERTIFY) Start/End Dates: 05/05/2023-11/05/2023. This certification did not limit the length of each session or the number of units performed during the session.

   The explanation of benefits also refers to a Medicare payment policy regarding Medically Unlikely Edit (MUE). MUE's were implemented by Medicare in 2007. MUE's set a maximum number of units for a specific service that a provider would report under most circumstances for a single patient on a single date of service. Medicare developed MUE edits to detect potentially medically unnecessary services.

Although the DWC adopts Medicare payment policies by reference in applicable Rule §134.203, paragraph (a)(7) of that rule states that specific provisions contained in the Division of Workers' Compensation rules shall take precedence over any conflicting provision adopted the Medicare program.

The Medicare MUE payment policy is in direct conflict with Texas Labor Code §413.014 which requires that all determinations of medical necessity shall be made prospectively or retrospective through utilization review; and with Rule §134.600 which sets out the procedures for preauthorization and retrospective review of professional services such as those in dispute here. The DWC concludes that Labor Code §413.014 and 28 TAC §134.600 take precedence over Medicare MUE's; therefore, the respondent's denial reasons are not supported.

2. The applicable DWC fee guideline for physical therapy is 28 TAC §134.203 (b) (1) which requires the application of Medicare payment policies applicable to professional services.

   DWC Rule 28 TAC §134.203 (c)(1) states, "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…"

   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.

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

- The dates of service are May 12, 16, 19, 2023.
- The DWC conversion factor for 2023 is 64.83
- The Medicare conversion factor for 2023 is 33.8872
- MPPR rates are published by carrier and locality.
- Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 75211; therefore, the Medicare locality is "Dallas, Texas."

The following formula represents the calculation of the DWC MAR at §134.203 (c)(1) & (2).

(DWC Conversion Factor ÷ Medicare Conversion Factor) x Medicare Payment = MAR

Applicable 28 TAC 134.203(h) states that the total reimbursement is the lesser of the maximum allowable reimbursement (MAR) and the billed amount.

Date of Service	Code	Units	Medicare Payment	DWC Conversion Factor divided by Medicare Conversion Factor or 64.83 ÷ 33.8872 = 1.91 (MAR)	Billed Amount	Lesser of MAR and billed amount
May 12, 2023	97110-GP	6	$30.22 1st unit $22.99 2nd – 6th unit	$277.72	$346.86	$277.72
May 12, 2023	97112-GP	2	$26.09	$99.83	$132.76	$99.83
May 16, 2023	97110-GP	6	$30.22 1st unit $22.99 2nd – 6th unit	$277.72	$346.86	$277.72
May 16, 2023	97112-GP	2	$26.09	$99.83	$132.76	$99.83
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May 19, 2023	97112-GP	2	$26.09	$99.83	$132.76	$99.83
					Total	$1,132.65

The total allowable DWC fee guideline for physical therapy is $1,132.65 the insurance carrier paid $496.48. The amount due to the requestor for physical therapy services is $636.17.

3. The remaining professional services in dispute are,

- Office visit (99213) - The provider sees an established patient for an office visit or other outpatient visit involving evaluation and management. The visit involves a low level of

medical decision making and/or the provider spends 20-29 minutes of total time on the encounter on a single date.

The insurance carrier denied the claim with Reason Code N4 described above. This code does not deny or approve the code nor does the P12 or WOCP reason codes. The carrier reason codes are not supported. The disputed service will be reviewed per applicable fee guideline.

DWC Rule 28 TAC §134.203 (c)(1) detailed above allows the reimbursement as, DWC Conversion factor/Medicare Conversion factor multiplied by physician fee schedule allowable for location or, 64.83/33.8872 x $91.32 = $174.70

- Team conference (99361-W1). The insurance carrier denied as documentation required to support requirements of Rule 134.202(e) (3), DWC Rule 134.204 (e)(2) states, 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.

  Review of the submitted "Team Conference" does not indicate a documented change in the condition of the injured employee. No payment is recommended for date May 16, 2023.

- Work status report (99080-73). The insurance carrier denied as submitted information does not support number/frequency of services. DWC Rule 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.

     Review of the submitted Work Status Report for Date of Service May 16, 2023 did not meet the requirements of applicable rule. No payment recommended.

4. The amount due to the requestor for physical therapy services is $636.17. The amount due for the office visit is $174.70. Total amount due to the requestor is $810.87. This amount 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 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $783.30 reimbursement for the disputed services. It is ordered that Zurich American Insurance Co must remit to Peak Integrated Healthcare $810.87 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		September 29, 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.