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
Texas Mutual Insurance Co.

MFDR Tracking Number
M4-25-0212-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
September 17, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 12, 2024	99213	$185.89	$185.89
June 12, 2024	99080-73	$15.00	$0.00
June 12, 2024	97110-GP	$85.92	$0.00
June 12, 2024	97112-GP	$17.07	$0.00
	Total	$303.88	$185.89

Requestor's Position

"WE DISAGREE THAT THIS BILL FOR AN OFFICE VISIT AS WELL AS THERAPY SHOULD NOT BE PAID. PATIENT WAS SEEN AS NECESSARY FOR THEIR CARE FOR AN OFFICE VISIT AS WELL AS HAVING THERAPY. BOTH SHOULD BE PAID IN FULL..."

Amount in Dispute: $303.88

Respondent's Supplemental Position

"For proper reimbursement, CPT code 99213 should have modifier 25 added to identify it as a separately identifiable service. The work status report was denied as there were no changes in the work status or restrictions from the previous TWCC-73 (attached). Our position is that no additional payment is due."

Response Submitted by: Texas Mutual Insurance Co.

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 §133.307 sets out the procedures for Medical Fee Dispute Resolution requests.
2. 28 TAC §134.203 set out the fee guidelines for professional medical services.

Adjustment Reasons

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

- P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 150 - PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE.
- 864 - E/M SERVICES MAY BE REPORTED ONLY IF THE PATIENTS CONDITION REQUIRES A SIGNIFICANT SEPARATELY IDENTIFIABLE E/M SERVICE.
- 248 – DWC-73 IN EXCESS OF THE FILING REQUIREMENTS; NO CHANGE IN WORK STATUS AND/OR RESTRICTIONS; REIMBURSEMENT DENIED PER RULE 129.5.
- G15 - PRICING IS CALCULATED BASED ON THE MEDICAL PROFESSIONAL FEE SCHEDULE VALUE.
- J31 - THE THERAPY SERVICE CODE HAS BEEN REDUCED PER THE MEDICARE MULTIPLE PROCEDURE RULE FOR THERAPY SERVICES.
- J16 - THIS PROCEDURE CODE WAS RANKED AS THE PRIMARY SERVICE WHEN CONSIDERED FOR MULTIPLE PROCEDURE REDUCTION. AS A RESULT, NO REDUCTION WAS TAKEN.
- 193 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

- W3 - IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. Is the insurance carrier's denial reason of CPT code 99213 supported and is the requestor entitled to reimbursement for this disputed service?
2. Is the insurance carrier's denial reason of the Work Status Report billed under CPT code 99080-73 supported and is the requestor entitled to reimbursement for this disputed service?
3. Is the insurance carrier's reimbursement reduction reason for CPT codes 97110 and 97112 supported?
4. Is the requestor entitled to additional reimbursement for CPT codes 97110 and 97112 rendered on the disputed date of service?
5. What is the total amount due to the requestor for the services in dispute?

Findings

1. A review of the submitted documentation finds that on the disputed date of service the requestor billed for an evaluation and management (E/M) office visit, CPT 99213, on the same bill and date of service with therapy services billed under CPT codes 97110-GP and 97112-GP.

   The insurance carrier denied reimbursement for CPT code 99213 with denial reasons indicating that the level of service billed is not supported by documentation and that the E/M service may only be reimbursed if the patient's condition requires a significant, separately identifiable evaluation.

   28 TAC §134.203(b)(1), which applies to the reimbursement of the disputed services, 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."

   DWC completed NCCI edits and found that on the disputed date of service no conflicts exist with the billing of CPT codes 97110, 97112 and 99213 together.

   DWC finds that the insurance carrier's denial reason of CPT code 99213 is not supported. Therefore, the requestor is entitled to reimbursement. The requestor is seeking reimbursement in the amount of $185.89 for disputed CPT code 99213 rendered on June 12, 2024.

CPT Code 99213 is defined as, "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 (MDM). When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter."

DWC finds that 28 TAC §134.203 applies to the billing and reimbursement of the disputed evaluation and management service, CPT code 99213.

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."

28 TAC §134.203(c) states in pertinent part, "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. 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 = MAR.

- The disputed date of service is June 12, 2024.
- The disputed service was rendered in zip code 75211, locality 11, Dallas; carrier 4412.
- The Medicare participating amount for CPT code 99213 in 2024 at this locality is $91.25.
- The 2024 DWC Conversion Factor is 67.81.
- The 2024 Medicare Conversion Factor on the disputed date of service is 33.2875.
- Using the above formula, DWC finds the MAR is $185.89 for CPT code 99213 on the disputed date of service.
- The respondent paid $0.00.
- Reimbursement in the amount of $185.89 is recommended for CPT code 99213 rendered on the disputed date of service.

2. The insurance carrier denied payment for CPT code 99080-73 rendered on June 12, 2024, citing that the Work Status Report, DWC-73 was in excess of the filing requirements as there was no change in the injured employee's work status or restrictions.

28 TAC §129.5 which applies to the disputed Work Status Report, states in pertinent part "(b) If authorized under their licensing act, a treating doctor may delegate authority to complete, sign, and file a work status report to a licensed physician assistant or a licensed advanced practice registered nurse as authorized under Texas Labor Code §408.025(a-1). The delegating treating doctor is responsible for the acts of the physician assistant and the advanced practice registered nurse under this subsection…

(e) 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…"

A comparative review of the submitted Work Status Reports dated May 29, 2024, and June 12, 2024, finds no change in work status or activity restrictions was documented.

DWC finds that the insurance carrier's reason for denial of CPT code 99080-73 rendered on June 12, 2024, is supported. As a result, DWC finds that the requestor is not entitled to reimbursement for CPT code 99080-73 on the disputed date of service.

3. The insurance carrier reduced the disputed CPT codes 97110-GP and 97112-GP citing the reduction reason is due to the Medicare Multiple Procedure Reduction Rule for therapy services.

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."

The requestor appended the above CPT codes with modifier "GP" which indicates the service was delivered by a physical therapist or under an outpatient physical therapy plan of care.

The fee guidelines applicable to the services in dispute are found at 28 TAC §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 (MPPR) 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 the 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.

DWC finds that the MPPR discounting rule applies to the disputed services. Therefore, DWC concludes that the insurance carrier's reason for the reimbursement reduction is supported.

4. The requestor is seeking additional reimbursement in the amount of $85.92 for six units of CPT code 97110-GP and in the amount of $17.07 for two units of CPT code 97112-GP rendered on June 12, 2024. These disputed CPT codes are described in finding number three above.

   The MPPR Rate File that contains the payments for 2024 services is found at: www.cms.gov/Medicare/Billing/TherapyServices/index.html.

   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 date 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 75211; 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 2024 DWC Conversion Factor is 67.81
- The 2024 Medicare Conversion Factor for the disputed date of service is 33.2875
- The Medicare Participating amount for CPT code 97112 at locality 11 in 2024, is $33.33 for the first unit and $25.08 for the subsequent units.
- Using the above formula, DWC finds the MAR is $67.90 for the first unit and $51.09 for the second unit.
- DWC finds that the MAR for 2 units of 97112 on the disputed date of service in locality 11 is $118.99.
- The insurance carrier paid $120.97.
- No additional reimbursement is recommended.
- The Medicare Participating MPPR discount amount for CPT code 97110 at locality 11 in 2024 is $22.11.
- Using the above formula, DWC finds the MAR for CPT code 97110 x 6 units rendered on the disputed date of service = $270.24.
- The insurance carrier paid $274.74.
- No additional reimbursement is recommended.
- DWC finds that the total MAR for 2 units of CPT code 97112 plus 6 units of CPT code 97110 rendered on the disputed date of service is $389.23.
- The insurance carrier paid $395.71.
- No additional reimbursement is recommended for CPT codes 97112 and 97110 rendered on June 12, 2024.

5. The requestor is seeking additional reimbursement in the total amount of $303.88 for services rendered on June 12, 2024.

   DWC's review of this medical fee dispute resolution (MFDR) request finds that the total MAR for the disputed services rendered on June 12, 2024, is $575.12.

   A review of the EOBs submitted finds that the insurance carrier paid a total amount of $395.71 for services rendered on the disputed date.

DWC finds that the requestor is entitled to reimbursement in the amount of $185.89 for CPT code 99213 rendered on June 12, 2024.

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 requestor has established that reimbursement is due in the amount of $185.89 for CPT code 99213.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement. It is ordered that Texas Mutual Insurance Co. must remit to Peak Integrated Healthcare $185.89 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature:

		October 18, 2024
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, 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.tas.gov.