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
M4-25-0621-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
November 13, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 7, 2024	97110-GP	$85.92	$0.00
August 7, 2024	97112-GP	$25.45	$6.40
August 22, 2024	97110-GP	$360.66	$0.00
August 22, 2024	97112-GP	$138.04	$0.00
August 22, 2024	99213	$185.89	$0.00
August 22, 2024	99080-73	$15.00	$15.00
	Total	$810.96	$21.40

Requestor's Position

"These bills were denied payment, or FULL payment due to 'workers compensation jurisdictional fee adjustment ', and 'plan procedures not followed' This is incorrect. THERAPY was AUTHORIZED."

Amount in Dispute: $810.96

Respondent's Supplemental Position

"The services on August 7, 2024, were reduced based upon the medical fee guidelines. The services on August 22, 2024, were denied because the plan procedures wer[e] not followed."

Response Submitted by: Flahive, Ogden & Latson

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 (MFDR) requests.
2. 28 TAC §134.203 set out the fee guidelines for professional medical services.
3. 28 TAC §129.5 sets out the guidelines for DWC073, Work Status Reports.

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.
- P13 – PAYMENT REDUCED OR DENIED BASED ON WORKERS COMPENSATION JURISDICTIONAL REGULATIONS OR PAYMENT POLICIES.
- 18 – EXACT DUPLICATE CLAIM/SERVICE.
- 95 – PLAN PROCEDURES NOT FOLLOWED.

Issues

1. Is the requestor entitled to additional reimbursement for CPT codes 97110 and 97112 rendered on August 7, 2024?
2. Is the requestor entitled to reimbursement for CPT codes 97110 and 97112 rendered on August 22, 2024?
3. Is the requestor entitled to reimbursement for CPT code 99213 rendered on August 22, 2024?
4. Is the requestor entitled to reimbursement for the Work Status Report, billed under procedure code 99080-73 and rendered on August 22, 2024?

Findings

1. 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 $25.45 for two units of CPT code 97112-GP rendered on August 7, 2024.

   A review of the explanation of benefits (EOB) documents submitted finds that the insurance carrier reduced the reimbursement for disputed CPT codes 97110-GP and 97112-GP. 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.

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 $112.59.

- 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.
- 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 $393.73.
- The insurance carrier paid $387.33.
- Additional reimbursement in the amount of $6.40 is recommended for CPT codes 97112 and 97110 rendered on August 7, 2024.

2. The requestor is seeking reimbursement in the amount of $360.66 for six units of CPT code 97110-GP and in the amount of $138.04 for two units of CPT code 97112-GP rendered on August 22, 2024.

   A review of the explanation of benefits (EOB) documents submitted finds that the insurance carrier denied reimbursement for disputed CPT codes 97110-GP and 97112-GP rendered on August 22, 2024, referencing denial reason code 95, "plan procedures not followed."

   28 TAC §133.307(c)(2)(M) states, "Requests for MFDR must be legible and filed in the form and manner prescribed by the division… (2) Health Care Provider or Pharmacy Processing Agent Request. The requestor must send the request to the division in the form and manner prescribed by the division by any mail service, personal delivery, or electronic transmission as described in §102.5 of this title. The request must include: (M) a copy of all applicable medical records related to the dates of service in dispute;"

   A review of the medical records submitted finds that the dates of service on the therapy log/record are not legible, therefore, DWC cannot ascertain whether the services were provided on the disputed date of service. Because the disputed date of service, August 22, 2024, is not legibly supported by the submitted documents, DWC finds that the requestor is not entitled to reimbursement for CPT codes 97110-GP and 97112-GP, billed for date of service August 22, 2024.

3. A review of the submitted documentation finds that on the disputed date of service, August 22, 2024, the requestor billed for an evaluation and management (E/M) office visit, CPT 99213. The requestor is seeking reimbursement in the amount of $185.89 for CPT code 99213 rendered on August 22, 2024.

   The insurance carrier denied reimbursement for CPT code 99213 with denial reason 95, "plan procedures not followed."

   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." Medicare payment policies require that coding and billing of CPT codes meets the definition of the American Medical Association (AMA) CPT Code and Guidelines.

CPT Code 99213 is defined by the AMA 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."

The American Medical Association (AMA) CPT Code and Guideline Changes, effective January 1, 2021, can be found at: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf. In summary, CPT code 99213 documentation must contain two out of three of the following elements: 1) low level of number and complexity of problems addressed 2) limited level of amount and/or complexity of data to be reviewed and analyzed 3) low risk of morbidity/mortality of patient management OR must document 20-29 minutes of total time spent on the date of patient encounter.

An interactive E&M scoresheet tool is available at:
www.novitas-solutions.com/webcenter/portal/MedicareJL/EMScoreSheet

A review of the submitted medical documentation finds that a low level of MDM was not met in the elements of 1) Amount or complexity of data reviewed and analyzed 2) Risk of morbidity or mortality of patient management. The submitted medical record shows no documentation of time spent on the date of encounter. For these reasons, medical documentation submitted did not meet AMA criteria for reimbursement of CPT code 99213. As a result, the requestor is not entitled to reimbursement for CPT code 99213 rendered on August 22, 2024.

4. The requestor is seeking reimbursement in the amount of $15.00 for procedure code 99080-73, Work Status Report, rendered on August 22, 2024. A review of the EOB submitted finds that the insurance carrier denied payment for this service.

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…

(j)… The amount of reimbursement shall be $15. A doctor shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section... Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section."

A review of the submitted Work Status Report dated August 22, 2024, finds that a change in work status was documented. The billing and documentation of the Work Status Report met the requirements as outlined in 28 TAC §129.5. As a result, DWC finds that the requestor is entitled to reimbursement for CPT code 99080-73 in the amount of $15.00.

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 $6.40 for CPT codes 97110-GP and 97112-GP rendered on August 7, 2024 and in the amount of $15.00 for procedure code 99080-73 rendered on August 22, 2024, for a total of $21.40 due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement. It is ordered that Zurich American Insurance Co. must remit to Peak Integrated Healthcare $21.40 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature:

		January 13, 2025
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.