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

General Information

Requestor Name
ROBERT ZUNIGA, MD

Respondent Name
TECHNOLOGY INSURANCE COMPANY

MFDR Tracking Number
M4-23-0375-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
October 13, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 30, 2022	97530-GP, 97710-GP, 97112-GP, and 97124-GP	$343.40	$279.54
	Total	$343.40	$279.54

Requestor's Position

"Our office received an explanation of review for date of service: 03/30/2022 however, based on explanation codes; P12 (workers compensation jurisdictional fee schedule adjustment) 205 (this charge was disallowed as additional information/definition is required to clarify service/supply rendered) 16 (lacks information). 2nd denial states the same, I have reviewed the notes and the documentation does support the charges, also included other dates of services that were submitted together and paid correctly."

Amount in Dispute: $343.40

Respondent's Position

"In this matter, Requestor billed bill for several therapeutic modalities, but each specific type of therapy performed was not documented in the record, nor was the complete time bill. Therefore, the billed services were denied due to the insufficient medical documentation. In conclusion, reimbursement is not owed for physical therapy when it is not properly documented."

Submitted By: Downs Stanford, P.C.

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 §134.239 sets out the guidelines for billing for work status reports.
4. 28 TAC §129.5 sets out the guidelines for work status reports.

Denial Reasons

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

- 205-THIS CHARGE WAS DISALLOWED AS ADDITIONAL INFORMATION/DEFINITION IS REQUIRED TO CLARIFY SERVICE/SUPPLY RENDERED.
- 16-CLAIM LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S).
- P12-WORKERS COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 350-BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 790-THIS CHARGE WAS REIMBURSED IN ACCORDANCE WITH THE TEXAS MEDICAL FEE GUIDELINES.
- P13-PAYMENT REDUCED OR DENIED BASED ON WORKERS' COMPENSATION JURISDICTIONAL REGULATIONS OR PAYMENT POLICIES.
- U03-THE BILLED SERVICE WAS REVIEWED BY UR AND AUTHORIZED.
- W3-IN ACCORDANCE WI1H TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. Did the insurance carrier raise a new issue after the filing of the MDR?
2. Are the insurance carrier's denial reasons supported?
3. What is the definition of CPT Code 97530-GP, 97110-GP, 97112-GP, and 97124-GP?
4. Do the disputed services contain NCCI edits that may affect reimbursement?
5. Does the MPPR apply to CPT Codes 97530-GP, 97110-GP, 97112-GP, and 97124-GP?
6. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Codes 97530-GP, 97110-GP, 97112-GP, and 97124-GP rendered on March 30, 2022.

   Review of the insurance carrier's response finds new denial reasons or defenses raised that were not presented to the requestor before the filing of the request for medical fee dispute resolution. Rule §133.307(d)(2)(B) requires that upon receipt of the request for medical fee dispute resolution, the respondent shall provide any missing information not provided by the requestor and known to the respondent, including: a paper copy of all initial and appeal EOBs related to the dispute, as originally submitted to the health care provider… related to the health care in dispute not submitted by the requestor or a statement certifying that the respondent did not receive the health care provider's disputed billing prior to the dispute request.

   Review of the submitted information finds insufficient documentation to support an EOB was presented to the health care provider giving notice of the lack of documentation denial reason or defense raised in the insurance carrier's response to MFDR.

   Rule §133.307(d)(2)(F) requires that: The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

   Pursuant to Rule §133.307(d)(2)(F), the insurance carrier's failure to give notice to the health care provider of specific codes or explanations for reduction or denial of payment as required by Rule §133.240 , the DWC finds the respondent has raised new denial reasons or defenses. The carrier failed to give notice to the health care provider during the medical bill review process or before the filing of this dispute. Consequently, the division concludes the insurance carrier has waived the right to raise a new denial reason or defense during dispute resolution. Any such new defenses or denial reasons will not be considered in this review.

2. The insurance carrier denied the disputed services with denial reason codes indicated above. Review of the medical records and the medical bills finds that the requestor submitted sufficient documentation to support the billing of the disputed services. As a result, the insurance carrier's denial reasons are not supported. The disputed services are therefore reviewed pursuant to the applicable rules and guidelines.

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."

   CPT Code 97530 is defined as, "Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes."

   CPT code 97110 is defined as, "Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility."

CPT Code 97712 is defined as, "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."

CPT code 97124 is defined as, "Therapeutic procedure, 1 or more areas, each **15** minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)."

The DWC finds that the requestor rendered the services as billed, as a result, the disputed CPT codes are reviewed pursuant to the applicable rules and guidelines.

4. The requestor billed CPT Codes 97530-GP, 97110-GP, 97112-GP, and 97124-GP.

   The DWC completed NCCI edits to identify if the services rendered on March 30, 2022 contain NCCI edits, that may affect reimbursement.

   The requestor billed CPT Code 97530, 97110, 97112 and 97124. The following was identified:

   CPT Code 97530 - This charge line did not trigger edits and is considered clean.

   CPT Code 97110 - This charge line did not trigger edits and is considered clean.

   CPT Code 97112 – This charge line did not trigger edits and is considered clean.

   CPT Code 97124 - This charge line did not trigger edits and is considered clean.

   The DWC finds that the disputed services do not contain NCCI edits that may affect reimbursement. As a result, the requestor is entitled to reimbursement for the services in dispute.

5. The fee guidelines for disputed services is found at 28 TAC §134.203.

   28 TAC §134.203(a)(5) states, "'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.

   The requestor appended the "GP" modifier to both codes. The "GP" modifier is described as "Services delivered under an outpatient physical therapy plan of care."

   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 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 2022 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 finds that the firsts unit of CPT Code 97530 is subject to the MPPR, along with CPT Codes 97112, 97110 and 97124.

Review of the Medicare published list for 2022 finds that the PE RVU for CPT 97530 is 0.64, which has the highest RVU on that day, therefore the reduced PE payment applies to all other services.

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..."

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

The MPPR rates are published by carrier and locality.

Code	Short Descriptor	Fee Amount	50% Reduction	Practice Expense RVUs	# of units billed	# of units subject to the MPPR
97530	Therapeutic activities	$36.78		0.64	1 unit	
97530	Therapeutic activities	$36.78	$26.21		1 unit	1 unit
97112	Neuromuscular reeducation	$33.9	$25.8	0.49	1 unit	1 unit
97110	Therapeutic exercises	$29.2	$22.59	0.40	2 units	2 unit
97124	Massage therapy	$29.5	$20.91	0.52	1 unit	1 unit

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

- The disputed services were rendered in 2022.
- 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 78504; therefore, the Medicare locality is "Rest of Texas."
- Using the above formula, the MAR is indicated below:

Dates of Service	CPT Code	# Units	MAR	Insurance Carrier Paid	Amount Sought	Amount Recommended
3/30/22	97530	1	$66.38	$0.00	$130.00	$66.38
	97530	1	$47.31	$0.00		$47.31
3/30/22	97112	1	$46.57	$0.00	$60.00	$46.57
3/30/22	97110	2	$81.54	$0.00	$105.40	$81.54
3/30/22	97124	1	$37.74	$0.00	$48.00	$37.74
Totals			$279.54	$0.00	$343.40	$279.54

The DWC finds that the requestor is therefore entitled to a total recommended amount of $279.54, for CPT Codes 97530, 97110, 97112 and 97124.

6. The DWC finds that due to the reasons indicated above, the requestor is entitled to a total reimbursement amount of $279.54. 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.

The DWC finds the requester has established that reimbursement of $279.54 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor $279.54 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		December 19, 2022
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.