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

General Information

Requestor Name
NORTH TEXAS REHABILITATION

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-23-1040-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
January 6, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 14, 2022 through July 7, 2022	97110-GP, and 97530-GP	$2,849.02	$0.00
	Total	$2,849.02	$0.00

Requestor's Position

"We have indicated that the bill is for the service, and the time and treatment using that code are indicated. As for the rest of the EOB stating why we are using skilled services, this was determined in our Pre-Cert request, where medical necessity was established… and Approved. As for the license type, number, and jurisdiction, we have corrected this information and updated notes."

Amount in Dispute: $2,849.02

Respondent's Position

"The bills were denied with reason code/message modifier 892, 225 which the auditor explains that the documentation does not support time spent on skilled service... The provider submitted appeals on each bill, review of the appeals received do not support or confirm the provider submitted correct the bills to include appropriate modifier required for PT/OT services by the 'Assistant' per CMS billing guidelines, nor did the provider include PTA information in box 24J as the rendering provider per documentation submitted, nor the… the billing units and documentation clarified or amended to support the appropriate billed units versus 'time' rendered."

Submitted by: Texas Mutual Insurance 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.

Denial Reasons

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

- 892/225 - DOCU DOES NOT SUPPORT TIME SPENT ON CONSTANT ATTENDANCE 1 :1 THERAPY CODES AND DOES NOT INDICATE WHY INJURED WORKER NEEDED CONSTANT ATTENDANCE/SKILLED SERVICE. 892,225- PUB. 100-02, MEDICARE BENEFIT POLICY MANUAL, CHAPTER 15, SECTION 220.3E, DOCUMENTATION REQUIREMENTS FOR THERAPY SERVICES, INDICATES THAT THE TOTAL TIMED CODE MINUTES AND TOTAL TREATMENT TIME IN MINUTES MUST BE DOCUMENTED. TOTAL TREATMENT TIME INCLUDES BOTH TIMED CODES AND UNTIMED CODES.
- 892/225 - DOCU DOES NOT SUPPORT TIME SPENT ON SKILLED SERVICE/CONSTANT ATTENDANCE 1:1/SKILLED THERAPY CODES AND DOES NOT INDICATE WHY INJURED WORKER NEEDED CONSTANT ATTENDANCE/SKILLED SERVICE.
- A19-DWC RULES 133.10, 133.20 & CLEAN CLAIM GUIDE REQUIRE LICENSE TYPE, TAX ID, NPI & STATE JURISDICTION OF LICENSED HCP WHO RENDERED SERVICES.
- CAC-P12- WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- CAC-W3-IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- CAC-16 CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION.
- CAC-193 ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIIM WAS PROCESSED PROPERLY.
- CAC-4 THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.
- 225-THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
- 732-ACCURATE CODING IS ESSENTIAL FOR REIMBURSEMENT. MODIFIER BILLED INCORRECTLY OR MISSING. SERVICES ARE NOT REIMBURSABLE AS BILLED.
- 891-NO ADDITIONAL PAYMENT AFTER RECONSIDERATION.
- 892-DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE DESCRIPTIONS/INSTRUCTIONS.

Issues

1. What is the description of the disputed services?
2. Was the requestor required to bill with CQ/CO or CA/CO modifiers?
3. Is the requestor entitled to reimbursement for CPT Codes 97110-GP, and 97530-GP?

Findings

1. The requestor seeks reimbursement for CPT Codes, 97110-GP, and 97530-GP rendered on June 14, 2022 through July 7, 2022.

   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."

   The requestor billed CPT Codes 97110 and 97530 and appended modifier -GP.

   - CPT Code 97110 is described as, "Therapeutic procedure, 1 or more areas, each **15** minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility."
   - CPT Code 97530 is described as, "Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each **15** minutes."
   - Modifier – GP is described as, "Services delivered under an outpatient physical therapy plan of care."

   The DWC finds that 28 TAC §134.203 applies to the billing and reimbursement of CPT Codes, 97110-GP, and 97530-GP.

2. The insurance carrier denied CPT codes 97110 and 97530 with denial reduction codes indicated above.

   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."

A review of the Medicare Claims Processing Manual Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services, 10.4 - Claims Processing Requirements for Financial Limitations, section B. Requirements - Professional Claims states in pertinent part, "Claims containing any of the "always therapy" codes must have one of the therapy modifiers appended (GN, GO, GP). Contractors shall return claims for "always therapy" codes when they do not contain appropriate therapy modifiers for the applicable HCPCS codes. In addition, when any code on the list of therapy codes is submitted with specialty codes "65" (physical therapist in private practice), "67" (occupational therapist in private practice), or "15" (speech-language pathologist in private practice) they always represent therapy services, because they are provided by therapists. Contractors shall return claims for these services when they do not contain therapy modifiers for the applicable HCPCS codes."

In addition, Medicare Claims Processing Manual Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services, 20 - HCPCS Coding Requirement, section B. Applicable Outpatient Rehabilitation HCPCS Codes , states:

"The CMS identifies the codes listed at: http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage: as therapy services, regardless of the presence of a financial limitation. Therapy services include only physical therapy, occupational therapy, and speech-language pathology services. Therapist means only a physical therapist, occupational therapist, or speech language pathologist. Therapy modifiers are GP for physical therapy, GO for occupational therapy, and GN for speech-language pathology…"

A review of CMS, article, titled *"Billing Examples Using CQ/CO Modifiers for Services Furnished in Whole or in Part by PTAs and OTAs*, states, "**Section 53107 of the Bipartisan Budget Act** (BBA of 2018) added a new section 1834(v) of the Social Security Act which requires CMS, through the use of new modifiers, to make a reduced payment for occupational therapy and physical therapy services furnished in whole or in part by occupational therapy assistants (OTAs) and physical therapist assistants (PTAs) at 85 percent of the otherwise applicable Part B payment for the service effective January 1, 2022. Section 1834(v)(2) of the Act requires that: (a) by January 1, 2019, CMS must establish a modifier to indicate that a therapy service was furnished in whole or in part by an OTA or PTA; and (b) beginning January 1, 2020, each claim for a therapy service furnished in whole or in part by an OTA or PTA must include the modifier. Section 1834(v)(3) requires CMS to implement these amendments through notice and comment rulemaking. CMS has implemented these amendments through the annual physician fee schedule (PFS) rulemaking process for CY 2019 and CY 2020. See CY 2019 PFS final rule, 83 F.R. 59654-59660 (Nov. 23, 2018); CY 2020 PFS final rule and 84 F.R. 62702-62707 (Nov. 15, 2019)."

The information in the below Background Section is found in Chapter 5, Medicare Claims Processing Manual (MCPM), section 20.1 - *Discipline Specific Outpatient Rehabilitation Modifiers – All Claims*.

CMS has established two modifiers, CA and CO, to indicate services furnished in whole or in part by a PTA or OTA, respectively… Effective for claims with dates of service on and after January 1, 2020, the CQ and CO modifiers are required to be used, when applicable, for services furnished in whole or in part by a PTA or OTA on the claim line of the service, along with the respective GP or GO therapy modifier, to identify those services furnished in whole or in part by a PTA or OTA under a physical therapy or occupational therapy plan of care. For those practitioners submitting professional claims who are paid under the physician fee schedule (PFS), the CQ/CO modifiers apply to services of physical and occupational therapists in private practice (PTPPs and OTPPs).

The CQ and CO modifiers must be used when applicable for all outpatient therapy services for which payment is made under section 1848 (the PFS) or section 1834(k) of the Social Security Act (the Act). As such, the modifiers are required to be used for therapy services furnished by providers that submit institutional claims, including the following provider types: outpatient hospitals, rehabilitation agencies, skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities (CORFs). However, the CQ and CO modifiers are not applicable to claims from critical access hospitals or other providers that are not paid for outpatient therapy services under the PFS or section 1834(k) of the Act.

The CQ modifier must be reported with the GP therapy modifier and the CO modifier with the GO therapy modifier. Claims with modifiers not so paired will be rejected/returned as un-processable."

Review of the submitted documentation supports that the requestor appended modifier -GP to the disputed CPT codes, however, the requestor did not append modifier CQ/CO or CA/CO, which is required along with GP/GO modifiers. As a result, the insurance carrier's denial reasons of CAC-16, CAC-4, and 732 are supported.

3. The DWC finds that the requestor has not supported the fact that reimbursement for the disputed services is due. As a result, $0.00 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 is due in the amount of $0.00.

Order

Under Texas Labor Code §§413.031 and 413.019, the DWC has determined the requestor is due $0.00 for the services in dispute.

Authorized Signature

		December 4, 2023
Signature	Medical Fee Dispute Resolution Officer	

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 managing the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option three 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.