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
PATIENT CARE INJURY CLINIC, PA

Respondent Name
REDWOOD FIRE & CASUALTY INSURANCE COMPANY

MFDR Tracking Number
M4-23-1176-01

Carrier's Austin Representative
Box Number 12

DWC Date Received
January 23, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 19, 2022	97112-GP and G0283	$95.80	$0.00
	97110-GP and 97140-GP	$294.38	$40.13
	Total	$390.18	$40.13

Requestor's Position

"After requesting reconsideration in a timely fashion VIA mail to Berkshire Hathaway it is quite evident that the carrier is unwilling to reimburse our facility for services rendered. We submitted our bills and proper clinical documentation in a timely fashion. We feel that our facility should be paid according to the correct workers compensation fee schedule guidelines."

Amount in Dispute: $390.18

Respondent's Position

"Carrier properly calculated reimbursement in this case and stands by the reasons for reduction of payment set forth in its Explanation of Benefits and in its Response to Request for Reconsideration previously issued in this dispute.

Carrier correctly reimbursed Requestor pursuant to the applicable fee schedule for CPT Codes 97110, 97112, 97140, and G0183. Please see Carrier's EOBs and payment records, attached."

Response Submitted by: Shanley Price

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:

- P12 – The charge for this procedure exceeds the amount indicated in the fee schedule.
- MZ P12 – 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.
- JF P12 – Documentation submitted does not substantiate the service billed.
- W3 – Additional payment made on appeal/reconsideration.
- 01 – Workers' compensation jurisdictional fee schedule adjustment.
- @F – 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. What are the services in dispute?
2. Is the requestor entitled to reimbursement for CPT Codes 97112-GP and G0283?
3. Are the insurance carrier's denial reasons supported for CPT Codes 97140-GP, 97110-GP?
4. Does the Multiple Procedure Payment Reductions (MPPR) apply to the disputed services?
5. What is the recommended reimbursement amount for CPT Codes 97140-GP and 97110-GP?
6. Is the Requestor entitled to additional reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Codes 97110-GP, 97140-GP, 97112-GP and G0283 rendered on October 19, 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-GP, 97140-GP, 97112-GP and G0283 rendered on October 19, 2022.

- 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 97140 is described as, "Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each **15** minutes."
- CPT Code 97112 is described 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 G0283 is described as, "Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care."
- Modifier – GP is described as, "Services delivered under an outpatient physical therapy plan of care."

The DWC finds that 28 TAC §134.203 applies CPT Codes 97110-GP, 97140-GP, 97112-GP and G0283.

2. Review of the explanation of benefits (EOBs) supports that the insurance carrier issued payments for CPT Codes 97112-GP and G0283, per the medical fee guidelines, as a result, additional reimbursement cannot be recommended.

DOS	CPT CODE	AMT BILLED	AMT DISPUTE	AMT PAID	MAR	AMT ORDERED
10/19/22	97112 X 1	$70.65	$70.65	$64.85	$64.85	$0.00
	G0283 X 1	$25.15	$25.15	$17.63	$17.63	$0.00
		$390.18	$390.18	$251.51	$291.64	$40.13

3. Review of the medical documentation finds that the insurance carrier issued a partial payment for CPT Codes 97140-GP, 97110-GP, and denied the remaining charge with denial reduction codes indicated above. The DWC finds that the requestor submitted sufficient documentation to support the billing and documentation of CPT Codes, 97140-GP, 97110-GP.

   The DWC finds that the insurance carrier's denial reasons are not supported. The requestor is therefore entitled to an additional reimbursement for disputed CPT Codes, 97140-GP, 97110-GP.

4. The DWC will determine if the disputed CPT codes are subject to Medicare's Multiple Procedure Payment Reductions (MPPR).

   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 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.

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 find that CPT Codes 97140-GP, 97110-GP are subject to the MPPR policy.

The DWC finds that CPT Codes 97112-GP, G0283, 97140-GP, 97110-GP are subject to Medicare's MPPR. The chart below outlines the ranking for PE payment for each of the codes billed by the health care provider.

CMS MEDICAL PHYSICIANS FEE SCHEDULE (MPFS)							
CODE	# UNITS	SHORT DESCRIPTOR	CARRIER	LOCALITY	FEE AMT	50% REDUCTION	PRACTICE EXPENSE RVUs
97112	1	Neuromuscular reeducation	4412	18	$35.93	-------	0.49 (HIGHEST)
97110	3	Therapeutic exercises	4412	18	$30.94	$23.82	0.40
97140	2	Manual therapy	4412	18	$28.44	$22.21	0.35
G0283	1	Elec stim	4412	18	$12.79	$9.77	0.17
				TOTAL			

As shown above CPT Code 97112 has the highest PE payment amount for the services billed by the provider that day, therefore, the reduced PE payment applies to all other services.

5. 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.

   - MPPR rates are published by carrier and locality.
   - The service were rendered in zip code 77076; the Medicare locality is "Houston."
   - The carrier code for Texas is 4412 and the locality code for Houston is eighteen.

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

   The date of service was rendered in 2022.

   - The 2022 DWC Conversion Factor is 62.46.
   - The 2022 Medicare Conversion Factor is 34.6062.

   Using the above formula, the DWC finds the MAR is as follows:

CODE	# UNITS	MAR 100 %	MAR 50%	TOTAL DUE
97112	1	$64.85	-------	$0.00
97110	3		$42.99 X 3 = $128.98	$0.04
97140	2		$40.09 X 2 = $80.18	$40.09
G0283	1		$17.63	$0.00
		TOTAL	$291.64	$40.13

6. The DWC finds that the requestor is entitled to an additional payment amount of $40.13 for CPT codes 97110-GP and 97140-GP. Therefore, 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 is due in the amount of $40.13.

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 $40.13 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		April 24, 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 managing 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).