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

General Information

Requestor Name
Peak Integrated Healthcare

Respondent Name
American Zurich Insurance Co.

MFDR Tracking Number
M4-23-2709-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
June 23, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
04/26/2023	97116-GP	$231.24	$189.76
	Total	$231.24	$189.76

Requestor's Position

"We do not agree that we have reached maximum benefit of authorized services. Please process for payment."

Amount in Dispute: $231.24

Respondent's Position

"… we have escalated the bills in question for manual review to determine if additional monies are owed. We will provide a supplemental response once the bill auditing company has finalized their review."

Response Submitted by: Gallagher Bassett

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031and 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 §134.600 sets out the preauthorization guidelines for specific treatments and services.

Denial Reasons

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

- 119 – Benefit maximum for this time period or occurrence has been reached.
- B12 – Services not documented in patient's medical record.
- B13 – Previously Paid. Payment for this claim/service may have been provided in a previous payment.
- P4 – Workers' Compensation claim adjudicated as non-compensable. This payer not liable for claim or service/treatment.
- ZK10 – A payment or denial has already been recommended for this service.
- 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules.

Issues

1. Did the Insurance Carrier or its representative submit a response to this medical fee dispute?
2. Is the Insurance Carrier's denial reason(s) supported?
3. Is the Requestor entitled to reimbursement?

Findings

1. The insurance carrier's representative, Gallagher Bassett, submitted a statement dated July 11, 2023, to indicate that there would be a supplemental position statement submitted after a manual review and final determination of the medical bill.

   Per 28 Texas Administrative Code §133.307 (d)(1), if DWC does not receive the response within 14 calendar days of the dispute notification, then DWC may base its decision on the available information.

   As of the date of this medical fee dispute resolution (MFDR) review, DWC has not received the supplemental response from Gallagher Basset. Therefore, we will base this decision on the information available at the time of the review.

2. The requestor seeks reimbursement for CPT Code 97116-GP x 4 units rendered on April 26, 2023.

   The insurance carrier denied the disputed service with denial reason codes defined above.

   Review of submitted documentation finds no evidence that the benefit maximum for the disputed service has been reached.

   Review of submitted documentation finds that the requestor documented 55 minutes (4 units) of gait training therapy on the disputed date of service, rendered to the same patient as was identified on the medical bill.

   Review of submitted documentation finds no evidence that CPT code 97116-GP, rendered on the disputed date of service, has been previously reimbursed.

   Review of submitted documentation finds a utilization review dated March 30, 2023 preauthorizing 6 sessions of CPT code 97116, to be rendered between the dates of March 30, 2023 and June 30, 2023. In accordance with 28 TAC §134.600, "(l) The insurance carrier shall not withdraw a preauthorization or concurrent utilization review approval once issued. The approval shall include: (1) the specific health care; (2) the approved number of health care treatments and specific period of time to complete the treatments; (3) a notice of any unresolved dispute regarding the denial of compensability or liability or an unresolved dispute of extent of or relatedness to the compensable injury; and (4) the insurance carrier's preauthorization approval number that conforms to the standards described in §19.2009(a)(4) of this title (relating to Notice of Determinations Made in Utilization Review)."

   A review of the preauthorization letter finds that the disputed medical service was preauthorized and contains the required elements required per 28 TAC §134.600.

   The insurance carrier raised the issue of compensability, however, did not include a copy of a PLN11 to support this denial reason. As a result, the DWC finds no evidence that notice of an unresolved dispute of compensability was provided. DWC finds that the service of CPT code 97116-GP was preauthorized and provided during the approved time frame. The insurance carrier's denial reason is therefore not supported.

3. The requestor is seeking reimbursement for 4 units of disputed CPT code 97116-GP rendered on April 26, 2023. Because the insurance carrier's denial reasons are not supported, DWC finds that the requestor is entitled to reimbursement for the disputed service.

   CPT Code 97116 is described as Gait Training (includes stair climbing) (one or more areas, each 15 minutes). The requestor appended the code with modifier -GP, which indicates that the services were delivered under an outpatient physical therapy plan of care.

   The following TAC Rules apply to the reimbursement of the disputed service:

   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."

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 certain time-based physical therapy codes when more than one unit or procedure is provided to the same patient on the same day. DWC finds that the MPPR rule applies to the disputed service, CPT code 97116.

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..."

Medicare publishes a list of the codes subject to MPPR annually.

The MPPR Rate File that contains the payments for 2023 services is found at https://www.cms.gov/Medicare/Billing/TherapyServices/index.html.

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

- MPPR rates are published by carrier and locality.
- Disputed service was rendered in zip code 75211, locality 11, Dallas
- The disputed date of service is April 26, 2023.
- The Medicare participating amount for CPT code 97116 in 2023 at this locality is $30.22 for the first unit, and $22.99 for each subsequent 3 units.
- The 2023 DWC Conversion Factor is 64.83
- The 2023 Medicare Conversion Factor is 33.8872
- Using the above formula, the DWC finds the MAR is $189.76 for 4 units of CPT code 97116-GP rendered on April 26, 2023.
- The respondent paid $0.00
- Reimbursement in the amount of $189.76 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.

DWC finds the requester has established that reimbursement in the amount of $189.76 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, American Zurich Insurance Co., must remit to the Requestor, Peak Integrated Healthcare, $189.76 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		September 27, 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 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.