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

General Information

Requestor Name
One on One Physical Therapy

Respondent Name
ACE American Insurance Company

MFDR Tracking Number
M4-24-0755-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
November 30, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 26, 2023, through September 13, 2023	97112, 97140, 97530, and 97164	$4,190.00	$120.00
	Total	$4,190.00	$120.00

Requestor's Position

"I have 19 visits still pending payment for services rendered. I have received denials for all those dates of service. I would like these 19 visits to be reviewed and reconsidered for payment based on the medical necessity documentation by the therapist and from the original order from the physician. I have enclosed the HCFA 1500 claim forms, the clinical notes, and the EOB denials."

Amount in Dispute: $4,190.00

Respondent's Position

"To date, there have been no preauthorization requests for physical therapy services for the date ranges of 07/26/2023 – 09/13/2023. Note: Physical Therapy evaluations and reevaluations do not require preauthorization and were not denied when billed. The Requestor has received approval for physical therapy, but it is for dates beyond the dates included in this MFDR (36 visits, to occur between 10/5/23 and 01/05/2024)."

Submitted by: CorVel

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 medical fee guideline for professional medical services.
3. 28 TAC §134.600 sets out the guidelines for preauthorization, concurrent utilization review, and voluntary certification of health care.

Denial Reasons

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

- 197 – Payment adjusted for absence of precert/preauth.
- 352 – Network disc not applicable to procedure billed.
- 97A – Provider appeal.
- Note: Per rule 134.600, preauth is required for PT except for the first 6 visits within the first two weeks of the DOI or a surgical procedure. Your bill does not meet either exception, and preauth is required.

Issues

1. Were the disputed services rendered out of state?
2. What is the description of the disputed services?
3. Did the requestor submit documentation to support that preauthorization was obtained?
4. Is the Requestor entitled to reimbursement?

Findings

1. The requestor is a health care provider that rendered disputed services in Atlanta, Georgia to an injured employee with an existing Texas Workers' Compensation claim. The health care provider requested reconsideration from the insurance carrier and was dissatisfied with the insurance carrier's final action. The health care provider has requested medical fee dispute resolution under 28 TAC §133.307. Because the requestor has sought the administrative remedy outlined in 28 TAC §133.307 for resolution of the non-payment, the Division concludes that it has jurisdiction to decide the issue(s) in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules.

2. The requestor seeks reimbursement for CPT Codes, 97112, 97140, 97530, and 97164 rendered

on July 26, 2023, through September 13, 2023. The insurance carrier denied the disputed services due to absence of precertification/preauthorization. The requestor states, "I would like these 19 visits to be reviewed and reconsidered for payment based on the medical necessity documentation by the therapist and from the original order from the physician."

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 97112, 97140, 97530, and 97164 and appended modifier -GP.

- 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 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 97530 is described as, "Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each **15** minutes."
- CPT Code 97164 is described as, "Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, **20** minutes are spent face-to-face with the patient and/or family."
- 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, 97112, 97140, 97530, and 97164.

3. The insurance carrier denied CPT codes 97112, 97140, 97530, and 97164 due to absence of precertification/preauthorization. The requestor states, "I would like these 19 visits to be reviewed and reconsidered for payment based on the medical necessity documentation by the therapist and from the original order from the physician."

28 TAC 134.600 states, "(p) Non-emergency health care requiring preauthorization includes… (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:

(A) Level I code range for Physical Medicine and Rehabilitation, but limited to:

(i) Modalities, both supervised and constant attendance.

(ii) Therapeutic procedures, excluding work hardening and work conditioning.

(iii) Orthotics/Prosthetics Management.

(iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code…"

The DWC finds that the disputed CPT Codes 97112, 97140, and 97530 require preauthorization. CPT Code 97164 does not require preauthorization and therefore is reviewed pursuant to the applicable rules and guidelines.

A review of the preauthorization letter from CorVel, dated October 10, 2023, finds that the requestor obtained preauthorization for 36 visits for CPT codes 97110, 97112, 97140 and 97530, to be rendered October 5, 2023, through January 5, 2024.

A review of the medical bills and EOBs finds that the disputed dates of service are July 26, 2023, through September 13, 2023, prior to the preauthorization letter dated October 10, 2023. The DWC finds that the requestor did not submit sufficient documentation to support that preauthorization was obtained for the disputed services. Reimbursement is therefore not recommended.

4. 28 TAC §134.203 applies to the reimbursement of CPT Code 97164 rendered on September 8, 2023.

   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 2023 services is found at https://www.cms.gov/Medicare/Billing/TherapyServices/index.html.

   - MPPR rates are published by carrier and locality.
   - The services were provided in zip code 30341, GA.
   - To determine the MAR the following formula is used:

   (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

   Disputed date of service was rendered in 2023

   - The 2023 DWC Conversion Factor is 64.83
   - The 2023 Medicare Conversion Factor is 33.8872
   - The Medicare Participating amount for CPT code 97164 at this locality is $70.43.
   - Using the above formula, the DWC finds the MAR is $134.74.
   - The respondent paid $0.00.
   - The requestor seeks $120.00.
   - The requestor is due $120.00 for dates of service, September 8, 2023.

The DWC finds that the requestor is entitled to reimbursement in the amount of $120.00. 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 $120.00.

Order

Under Texas Labor Code §§413.031 and 413.019, the DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor $120.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		March 22, 2024
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.