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

General Information

Requestor Name
Therapeutic Conditioning & Rehab

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-24-1722-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
April 8, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 4, 2023	97110, and 97530	$200.00	$195.18
	Total	$200.00	$195.18

Requestor's Position

For this dispute, the requestor did not provide a position summary for review. As a result, the information available at the time of review served as the basis for this decision.

Amount in Dispute: $200.00

Respondent's Position

"The documentation submitted by the provider did not include a position statement for the disputed issue(s) as required by Rule 133.307(N)... The bills received and denied with A19 were billed under Eugenio Esguerra, PT which is not the rendering healthcare provider on the documentation that was received with the bill and matches what is included in the DWC-60 packet, reference page 11 and 12 of the DWC-60 packet. According to the documentation that was submitted the rendering provider is Annie Marie Esguerra, PT. The healthcare provider did not follow rule 133.20(d) resulting in the A19 denial. Rule 133.20(d) states the health care provider that provided the health care shall submit its own bill. According to research, Texas Mutual did not receive a medical bill from the rendering provider Annie Marie C. Esguerra until the DWC-60 packet was received on 4/15/2024, reference page 10 of the DWC-60 packets. The

health care provider did not follow rule 133.20(b-c). Rule 133.20(b-c) states except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statue, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied. The medical bill submitted by the health care provider to the correct workers' compensation insurance carrier is subject to the billing, review, and dispute processes established by Chapter 133, including §133.307(c)(2)(A) - (H) of this title (relating to MDR of Fee Disputes), which established the generally acceptable standards for documentation."

Response submitted by: Texas Mutual Insurance Company

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §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) §133.305 sets out the procedures for resolving medical disputes.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 TAC §134.203 sets out the fee guideline for professional medical services.
4. 28 TAC §133.20 sets out the guidelines for medical bill submission by Health Care Provider.

Denial Reasons

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

- A19 – Rendering provider must bill for services. Update box 24J and box 31 of the CMS-1500 to reflect the rendering providers information. Please correct CMS-1500 and submit a request for reconsideration.
- 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 & 350 – In accordance with TDI-DWC Rule 134.804. This bill has been identified as a request for reconsideration or appeal.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- CAC-4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.

- 732 – Accurate coding essential for reimbursement. Modifier billed incorrectly or missing. Services are not reimbursable as billed.
- 891 – No additional payment after reconsideration.
- 732 – Per CMS effective 1/1/22 CQ and CO modifiers are required to be used, when applicable for services furnished in whole or in part of a PTA or OTA. Refer to Rule 133.250 regarding request for reconsideration and submit with original EOB and corrected bill.
- CAC-18 – Exact duplicate claim/service.

Issues

1. What are the services in dispute?
2. Is the insurance carrier's denial reason supported?
3. What is the description of the disputed CPT codes?
4. Is the requestor entitled to reimbursement?

Findings

1. This dispute pertains to the non-payment of CPT codes 97110, and 97530, rendered on August 4, 2023. The requestor appended modifiers -GP, -U5, and -59 to the disputed CPT codes. The requestor is seeking reimbursement in the amount of $200.00.

2. The requestor seeks reimbursement for physical therapy services rendered on August 4, 2023. The insurance carrier denied the disputed service with denial reduction codes, A19, and P12 (description provided above.)

   To determine if the requestor is entitled to reimbursement, the DWC reviewed the following rules and guidelines:

   28 TAC §133.10 (f)(1)(Z) states, "All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form. (1)The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care: (Z) signature of physician or supplier, the degrees or credentials, and the date (CMS-1500/field 31) is required, but the signature may be represented with a notation that the signature is on file and the typed name of the physician or supplier."

   28 TAC §133.20(d)(2) requires, "The health care provider that provided the health care shall submit its own bill, unless: the health care was provided by an unlicensed individual under the direct supervision of a licensed health care provider, in which case the supervising health care provider shall submit the bill."

   28 TAC §133.20(e)(2) requires, "A medical bill must be submitted: (2) in the name of the licensed health care provider that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care."

A review of the medical records and CMS-1500 finds that Annie Marie Esquerra, PT, DPT, is indicated as the provider of service. As a result, the insurance carrier's denial reason is not supported, and the requestor is entitled to reimbursement for CPT codes 97110, and 97530.

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."

   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.

4. 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 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…"

   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 2023 the codes subject to MPPR are found in CMS 1693F the CY 2023 PFS Final Rule Multiple Procedure Payment Reduction Files. Review of that list finds that CPT Codes 97110, and 97530 are subject to the MPPR policy.

The chart below outlines the ranking for PE payment for each of the codes billed by the health care provider.

CPT Code	Practice Expense
97110 x 3 units	0.40
97530 x 1 unit	0.64

As shown above CPT Code 97530 has the highest PE payment amount for the services billed by the provider that day, therefore, the reduced PE payment applies to all other subsequent units.

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 Mission, TX, zip code 78572.
- The carrier code for Texas is 4412 and the locality code for Rest of Texas is 99.

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

Dates of service 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 97530 at this locality is $36.41 per unit.

- Using the above formula, the DWC finds the MAR is $69.66.
- The respondent paid $0.00.
- The requestor is due $69.66.

The Medicare Participating amount for CPT code 97110 at this locality is $21.87 for each unit.

- Using the above formula, the DWC finds the MAR is $41.84 per unit x 3 units, for a total of $125.52.
- The respondent paid $0.00.
- The requestor is due $125.52.

The DWC finds that the requestor is due $195.18 for the disputed CPT codes 97530 x 1 unit, and 97110 x 2 units.

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.

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 $195.18 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 15, 2024 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, 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.