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
Peak Integrated Healthcare

Respondent Name
Vanliner Insurance Co.

MFDR Tracking Number
M4-24-1830-01

Carrier's Austin Representative
Box Number 6

DWC Date Received
April 18, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 5, 2023	99203	$216.18	Dismissed
December 5, 2023	99080-73	$15.00	Dismissed
December 11, 2023	97750-GP	$531.04	Dismissed
December 22, 2023	97110-GP	$231.24	$175.93
December 22, 2023	97112-GP	$16.47	$0.00
January 22, 2024	97110-GP	$82.98	$10.85
January 22, 2024	97112-GP	$32.94	$21.14
	Total	$1,172.65	$207.92

Requestor's Position

Regarding DOS 12/22/2023: "We never received a response to this reconsideration, and it should be paid in full."
Regarding DOS 1/22/2024: "1/22 remains unpaid."
Amount in Dispute: $1,172.65

Respondent's Position

"… although the ICD 10 codes appear to be for diagnoses that so far have been accepted by Vanliner as compensable, the actual treatment appears to be unrelated to those codes, resulting in an extent of injury issue."
Response Submitted by: STONE LOUGHLIN & SWANSON, LLP

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 Medical Fee Dispute Resolution requests.
2. 28 (TAC) §133.305 sets out general Medical Dispute Resolution guidelines.
3. 28 TAC §133.240 sets out the procedures for medical bill processing by insurance carriers.
4. 28 TAC §134.203 sets out the fee guidelines for professional medical services.

Adjustment Reasons

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

DOS December 5, 2023:

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- Comments: Extent of injury. Treatment is for non-compensable injuries. Claim has not yet been finally adjudicated.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

DOS December 11, 2023:

- 59 – Processed based on multiple or concurrent procedure rules.
- Comments: Extent of injury. Treatment is for non-compensable injuries. Claim has not yet been finally adjudicated.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.

- Comment: Extent of injury. Treatment cannot be verified to be related to the compensable injury/injuries. Further, UR only approved PT & not FCE. The claim has not yet been finally adjudicated.

DOS December 22, 2023:

- 59 – Processed based on multiple or concurrent procedure rules.

DOS January 22, 2024:

- 59 – Processed based on multiple or concurrent procedure rules.

Issues

1. Is the dispute for services rendered on December 5 and 11, 2023, subject to dismissal based on extent of injury?
2. Is the insurance carrier's payment reduction reason(s) for CPT code 97110-GP and 97112-GP rendered on December 22, 2023, supported?
3. Is the insurance carrier's payment reduction reason(s) for CPT code 97110-GP and 97112-GP rendered on January 22, 2024, supported?
4. Is the requestor entitled to additional reimbursement for any of the dates of service in dispute?

Findings

1. The requestor is seeking reimbursement for services rendered on December 5 and 11, 2023. The services in dispute were denied by the workers' compensation carrier due to an unresolved extent-of-injury dispute. Per submitted documentation and information known to DWC, the extent of injury denial was timely presented to the requestor in the manner required by 28 TAC §133.240.

   28 TAC §133.305(b) states, "Dispute Sequence. If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability, or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021."

   28 TAC §133.307(f)(3)(C) states in pertinent part, "Dismissal. A dismissal is not a final decision by the division. The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of this section. The division may dismiss a request for MFDR if… the request contains an unresolved compensability, extent of injury, or liability dispute for the claim;"

   The services in dispute rendered on December 5 and 11, 2023, contain unresolved extent-of-injury issues. For that reason, these dates of service are not eligible for adjudication of a medical fee dispute resolution. These disputed dates of service, December 5, 2023, and December 11, 2023, are hereby dismissed.

2. On the disputed date of service, December 22, 2023, the requestor charged $346.86 for CPT code 97110-GP x 6 units and charged $132.76 for CPT code 97112 x 2 units, for a total charge of $479.62. The insurance carrier reduced the payment for both disputed CPT codes based on multiple procedure discounting rules.

   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 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."

   The requestor appended the above CPT codes with modifier "GP" which indicates the service was delivered by a physical therapist or under an outpatient physical therapy plan of care.

   The fee guidelines applicable to the services in dispute are found at 28 TAC §134.203, which states in pertinent part, "(a)(5) '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 (MPPR) 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.

DWC finds that CPT Codes 97110 and 97112 are subject to the MPPR policy. Therefore, the insurance carrier's reimbursement reduction reason is supported.

3. On the disputed date of service, January 22, 2024, the requestor charged $360.72 for CPT code 97110-GP x 6 units and charged $138.04 for CPT code 97112 x 2 units, for a total charge of $498.76 for therapy services rendered. The insurance carrier reduced the payment for both CPT codes based on multiple procedure discounting rules.

   The disputed CPT codes are described in finding number 2 above.

   As demonstrated in finding number 2 above, CPT Codes 97110 and 97112 are subject to the MPPR policy. Therefore, the insurance carrier's reimbursement reduction reason is supported.

4. The requestor is seeking additional reimbursement in the following amounts:

   - $231.24 for CTP code 97110-GP rendered on December 22, 2023.
   - $16.47 for CPT code 97112-GP rendered on December 22, 2023.
   - $82.98 for CPT code 97110-GP rendered on January 22, 2024.
   - $32.94 for CPT code 97112-GP rendered on January 22, 2024.

   As established above, CPT Codes 97110 and 97112 are subject to the MPPR policy. The CPT code 97112 is found to have the highest PE/RVU of the therapeutic services billed on the disputed dates of service. Therefore, the first unit of CPT code 97112 will receive full payment and the reduced PE payment will apply to all subsequent units of timed therapy codes performed on the same date of service.

   The MPPR Rate File that contains the payments for 2023 and 2024 services is found at www.cms.gov/Medicare/Billing/TherapyServices/index.html.

   28 TAC §134.203, which applies to the reimbursement of the services in dispute, 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..."

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

- The 2023 DWC Conversion Factor is 64.83
- The 2023 Medicare Conversion Factor is 33.8872
- MPPR rates are published by carrier and locality.
- The disputed therapy services were rendered in zip code 75211, locality 11, Dallas.

CPT code 97112 x 2 units rendered on December 22, 2023

- The Medicare Participating amount in locality 11 is $34.70 for the first unit and $26.09 for the second unit.
- Using the above formula, DWC finds the MAR is $66.38 for the first unit and $49.91 for the second unit. Therefore, the MAR for 97112 x 2 units in 2023 = $116.29.
- The insurance carrier issued a payment in the amount of $116.29.
- The requestor was reimbursed the full MAR amount, as a result additional reimbursement is not recommended.

CPT code 97110 x 6 units rendered on December 22, 2023.

- The Medicare Participating MPPR amount in locality 11 is $22.99 per unit.
- Using the above formula, DWC finds the MAR is $43.98 x 6 units = $263.89.
- Per the EOB submitted, the insurance carrier allowed reimbursement in the amount of $87.96.
- The requestor is due an additional payment of $175.93.

- The 2024 DWC Conversion Factor is 67.81
- The 2024 Medicare Conversion Factor is 32.7442

CPT code 97112 x 2 units rendered on January 22, 2024

- The Medicare Participating amount in locality 11 is $33.33 for the first unit and $25.08 for the second unit.
- Using the above formula, DWC finds the MAR is $69.02 for the first unit and $51.94 for the second unit. Therefore, the MAR for 97112 x 2 units in 2024 = $120.96.
- The insurance carrier issued a payment in the amount of $99.82.
- The requestor is due an additional payment of $21.14.

CPT code 97110 x 6 units rendered on January 22, 2024

- The Medicare Participating MPPR amount in locality 11 is $22.11 per unit.
- Using the above formula, DWC finds the MAR for 97110 x 6 units in 2024 = $274.73.
- The insurance carrier issued a payment in the amount of $263.88.

- The requestor is due an additional payment of $10.85.

DWC finds that the requestor is entitled to additional reimbursement in the total amount of $207.92 for services rendered on the disputed dates December 22, 2023, and January 22, 2024.

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 requestor has established that reimbursement is due in the total amount of $207.92 for the disputed dates of service December 22, 2023, and January 22, 2024.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed dates of service December 22, 2023, and January 22, 2024. It is ordered that Vanliner Insurance Co., must remit to Peak Integrated Healthcare, $207.92 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature:

		May 24, 2024
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, 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.tas.gov.