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**
Starr Indemnity & Liability Co.

**MFDR Tracking Number**
M4-24-2520-01

**Carrier's Austin Representative**
Box Number 19

**DWC Date Received**
July 16, 2024

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| May 6, 2024 | 97110-GP | $71.60 | $0.00 |
| May 6, 2024 | 97112-GP | $138.04 | $0.00 |
| May 6, 2024 | 98940-GP | $0.00 | $0.00 |
| | **Total** | $209.64 | $0.00 |

## Requestor's Position

Excerpt from Request for Reconsideration: "These bills were denied payment due to 'EXCEEDS FEE SCHEDULE ALLOWANCE' This is INCORRECT. Therefore, these dates of service should be paid in full."

**Amount in Dispute:** $209.64

## Respondent's Supplemental Position

"We have completed our review of the State Dispute. As previously indicated, the bill as fee schedule priced to $345.08. 97112 was denied per NCCI guidelines."

**Response Submitted by:** Gallagher Bassett

## 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 §133.307 sets out the procedures for Medical Fee Dispute Resolution requests.
2. 28 TAC §134.203 set out the fee guidelines for professional medical services.

Adjustment Reasons

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

- 163 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE UNIT VALUE AND/OR THE MULTIPLE PROCEDURE RULES.
- 119 – BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED.
- 231 – MUTUALLY EXCLUSIVE PROCEDURES CANNOT BE DONE IN THE SAME DAY/SETTING.
- 6197 - IN ACCORDANCE WITH CLINICAL BASED CODING EDITS (NATIONAL CORRECT CODING INITIATIVE OUTPATIENT CODE EDITOR), COMPONENT CODE OF COMPREHENSIVE MEDICINE, EVALUATION.

Issues

1. Is the insurance carrier's denial reason of CPT code 97112-GP supported?
2. Is the insurance carrier's reimbursement reduction reason of CPT code 97110-GP supported?
3. Is the requestor entitled to additional reimbursement?

Findings

1. A review of the explanation of benefits (EOB) finds that the insurance carrier denied reimbursement for CPT code 97112-GP x 2 units with denial reasons 231 and 6197, defined above. Reason code 6197 refers to a National Correct Coding Initiative (NCCI) edit conflict.

28 TAC §134.203(b)(1) which applies to the services in dispute, 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."

A review of the submitted documents finds that on the disputed date of service, the requestor billed the following CPT codes together: 97110-GP x 6 units, 97112-GP x 2 units and 98940-GP x 1 unit. The insurance carrier allowed a reduced payment for CPT code 97110, denied all charges for CPT code 97112 and paid charges in full for CPT code 98940.

DWC completed NCCI edits and found that per Medicare NCCI Guidelines, CPT code 97112 has an unbundle relationship with procedure code 98940. These codes are not reimbursable when billed together on the same day unless an appropriate modifier is used and clearly documented. All CPT codes billed by the requestor on the disputed date of service were appended with modifier "GP" indicating services were delivered under an outpatient physical therapy plan of care. Modifier "GP" does not override the NCCI conflict that exists between CPT codes 97112 and 98940.

DWC finds that the insurance carrier's denial reason of CPT code 97112-GP based on an NCCI edit conflict is supported and therefore, no reimbursement is recommended.

2. According to the DWC060 Medical Fee Dispute Resolution (MFDR) form, the requestor is seeking additional reimbursement in the amount of $71.60 for 6 units of CPT code 97110-GP rendered on May 6, 2024.

   A review of the submitted explanation of benefits (EOB) document submitted finds that the insurance carrier reduced reimbursement for CPT code 97110-GP with reduction reason code 163, referring to the Multiple Procedure Payment Reduction (MPPR) Rule.

The disputed 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." The requestor appended CPT code 97110 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 the MPPR discounting rule applies to the disputed services. Therefore, DWC concludes that the insurance carrier's reason for the reimbursement reduction is supported.

3. The requestor is seeking additional reimbursement in the amount of $71.60 for 6 units of a therapy service billed under CPT code 97110-GP rendered on May 6, 2024.

   DWC finds that CPT code 97110 is subject to the MPPR policy.

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

   The first unit of CPT code 97110 will receive full payment, and the reduced PE payment will apply to all subsequent units.

   28 TAC §134.203, which applies to the reimbursement of the disputed services, states in pertinent part, "(c) To determine the maximum allowable reimbursement (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..."

- MPPR rates are published by carrier and locality.
- Per the medical bills, the services were rendered in zip code 75211; Medicare locality is 11, Dallas, TX.
- To determine the MAR the following formula is used:
  (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = MAR
- The 2024 DWC Conversion Factor is 67.81
- The Medicare Conversion Factor for 2024 is 33.2875
- The Medicare Participating amount for CPT code 97110 at locality 11 in 2024, is $29.03 for the first unit and $22.11 for each subsequent unit.
- Using the above formula, DWC finds the MAR is $59.14 for the first unit and $45.04 for each of 5 subsequent units.
- Therefore, the MAR for CPT code 97110 x 6 units rendered on the disputed date of service in locality 11 = $284.34.
- The insurance carrier paid $289.06 for CPT code 97110-GP x 6 units.
- No additional reimbursement is recommended.

DWC finds that no additional reimbursement is due.

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 not established that additional reimbursement is due.

## Order

Under Texas Labor Code §§413.031 and 413.019, the DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature:**

| | | |
|---|---|---|
| | | September 3, 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.