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
Service Lloyds Insurance Co.

MFDR Tracking Number
M4-24-2805-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
August 21, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 28, 2024	97110-GP	$360.66	$0.00
March 28, 2024	97112-GP	$138.04	$0.00
April 18, 2024	97750-GP	$557.52	$0.00
	Total	$1,056.22	$0.00

Requestor's Position

Excerpt from Request for Reconsideration regarding date of service March 28, 2024: "AFTER RECONSIDERATION WE RECEIVED NO RESPONSE OF DENIAL OR PAYMENT FOR THIS DATE OF SERVICE."

Excerpt from Request for Reconsideration regarding date of service April 18, 2024: "The above dates of service were not paid and have been returned due to the following reason: 'Not deemed a medical necessity.' This is incorrect."

Amount in Dispute: $1,056.22

Respondent's Supplemental Position

"We have reprocessed DOS 3/28/2024-04/18/2024 as requested... DOS 3/28/2024 Charged amount $501.58 processed per Fee Schedule for payment 398.59 which includes interest of 2.88. DOS 4/18/2024 Charged amount 557.52 processed per Fee Schedule for payment $418.31 which includes interest of 3.02. Payment total $816.90 which includes the interest owed."

Response Submitted by: Mitchell International

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:

- 181 - PROCEDURE CODE WAS INVALID ON THE DATE OF SERVICE.
- 225 & XDP – PENEALTY OR INTEREST PAYMENT BY PAYER.
- W3 & 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTITFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- F01 – THIS CODE IS NOT FOUND IN THE STATE'S FEE SCHEDULE.
- G15 – PRICING IS CALCULATTED BASED ON THE MEDICAL PROFESSIONAL FEE SCHEDULE VALUE.
- J16 – THIS PROCEDURE CODE WAS RANKED AS THE PRIMARY SERVICE WHEN CONSIDERED FOR MULTIPLE PROCEDURE REDUCTION. AS A RESULT NO REDUCTION WAS TAKEN.
- J31 – THE THERAPY SERVICE CODE AHS BEEN REDUCED PER THE MEDICARE MULTIPLE PROCEDURE RULE FOR THERAPY SERVICES.
- P12 & P13 – PAYMENT REDUCTION OR DENIED BASED ON WORKERS' COMPENSATION JURISDICTIONAL REGULATIONS OR PAYMENT POLICIES.
- U03 – THE BILLED SERVICE WAS REVIEWED BY UR AND AUTHORIZED.

- 50 - THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEBMED A MEDICAL NECESSITY BY THE PAYER.
- 777 - BASED ON Diagnosis. TREATMSNT PATTERNS AND/OR NUMBER OF VISITS, THE TREATMENT EXCEEDS OUR PHYSICIAN PARAMETERS. REFER TO DOCTOR'S REPORT.

Issues

1. Have the services in dispute been reimbursed after the request for medical fee dispute resolution (MFDR) was received by DWC?

2. What is the maximum allowable reimbursement (MAR) amount for disputed CPT codes 97110-GP and 97112-GP rendered on the disputed date of service?

3. What is the MAR amount for disputed CPT code 97750-GP rendered on the disputed date of service?

4. What is the total MAR for all the services in dispute?

5. Is the requestor entitled to additional reimbursement for the services in dispute?

Findings

1. A review of the explanation of benefits (EOB) submitted finds that the insurance carrier reprocessed and allowed reimbursement for the previously denied dates of service in dispute.

   A review of the EOB dated September 6, 2024, finds the following:

   - For date of service March 28, 2024, the insurance carrier allowed payment in the amount of $274.74 for six units of CPT code 97110-GP and allowed $120.97 for two units of CPT code 97112-GP, for a total allowance of $395.71 for services rendered on this disputed date. DWC notes that the insurance carrier included an interest payment in the amount of $2.88 on this EOB.
   - For date of service April 18, 2024, the insurance carrier allowed payment in the amount of $415.23 for eight units of CPT code 97750-GP. DWC notes that the insurance carrier included an interest payment in the amount of $3.08 on this EOB.
   - DWC finds that the insurance carrier has reimbursed the requestor by check dated September 9, 2024, in the total amount of $816.90. This payment included interest paid, therefore the total reimbursement for the disputed professional medical services is in the amount of $810.94.

   The request for MFDR was received by DWC on August 21, 2024. DWC finds that the services in dispute have been reimbursed in the amount of $810.94 on September 9, 2024, after the request for MFDR was received by DWC.

2. The requestor is seeking reimbursement in the amounts of $360.66 for six units of CPT code 97110-GP and in the amount of $138.04 for two units of CPT code 97112-GP.

As established in finding number one, these services have been reimbursed, after the request for MFDR, in the amounts shown above. DWC will review the disputed services in accordance with applicable DWC Rules to determine if additional reimbursement is due.

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, March 28, 2024, the requestor billed the following CPT codes: 97110-GP x 6 units, 97112-GP x 2 units. The insurance carrier allowed a reduced payment for both codes.

A review of the submitted EOB dated September 6, 2024, finds that the insurance carrier reduced reimbursement for CPT code 97110-GP and 97112-GP with reduction reasons 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 disputed 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 CPT code 97112 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. The CPT code 97112 is found to have the highest PE/RVU of the therapeutic services billed on the disputed date 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 2024 services is found at: www.cms.gov/Medicare/Billing/TherapyServices/index.html.

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 75043; 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 in 2024 on the disputed date of service is 33.2875

For CPT code 97112-GP:

- The Medicare Participating amount for CPT code 97112 at locality 11 in 2024, is $33.33 for the first unit and $25.08 for the subsequent units.
- Using the above formula, DWC finds the MAR is $67.90 for the first unit and $51.09 for the second unit. Therefore, the MAR for CPT code 97112 x 2 units rendered on the disputed date of service = $118.99.

For CPT code 97110-GP:

- 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 = $284.34.

3. The requestor is seeking reimbursement in the amount of $557.52 for eight units of CPT code 97750-GP rendered on April 18, 2024. CPT Code 97750-GP is defined as "Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes."

Per CMS' Billing and Coding: Outpatient Physical and Occupational Therapy Services, Article ID A56566, effective October 1, 2020:

> These tests and measurements are beyond the usual evaluation services performed. Examples of physical performance tests or measurements include isokinetic testing, Functional Capacity Evaluation (FCE) and Tinetti. This code may be used for the 6-minute walk test, with a computerized report of the patient's oxygen saturation levels with increasing stress levels, performed under a PT or OT plan of care on pulmonary rehabilitation patients.
>
> The therapy evaluation and re-evaluation codes are for a comprehensive review of the patient including, but not limited to, history, systems review, current clinical findings, establishment of a therapy diagnosis, and estimation of the prognosis and determination and/or revision of further treatment. CPT 97750 is intended to focus on patient performance of a specific activity or group of activities (CPT Assistant, December 2003).

There must be written evidence documenting the problem requiring the test, the specific test performed, and a separate measurement report. This report may include torque curves and other graphic reports with interpretation.

97750 should not be used to bill for patient assessments/re-assessments such as ROM testing or manual muscle testing completed at the start of care (as this is typically part of the examination included in the initial evaluation) and/or as the patient progresses through the episode of treatment.

Supportive Documentation Requirements (required at least every 10 visits) for 97750

- Problem requiring the test and the specific test performed
- Separate measurement report, including any graphic reports
- Application to functional activity
- How the test impacts the plan of care

Review of submitted medical documentation finds that on the disputed date of service, the healthcare provider documented a two hour (8 units) physical performance evaluation of the same injured employee named on the medical bill.

28 TAC §134.203 (c)(1) which applies to the reimbursement of the disputed service, states, "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…"

On the disputed date of service, the requestor billed CPT code 97550-GP x 8 units. As demonstrated above, DWC finds that the MPPR rule applies to 97750-GP.

The MPPR Rate File that contains the payments for 2024 services is found at: 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.
- The disputed date of service is April 18, 2024.
- The disputed service was rendered in zip code 75043, locality 11, Dallas; carrier 4412.
- The Medicare participating amount for CPT code 97750 in 2024 at this locality is $33.65 for the first unit, and $24.42 for the subsequent 7 units.
- The 2024 DWC Conversion Factor is 67.81
- The 2024 Medicare Conversion Factor on the disputed date of service is 33.2875.
- Using the above formula, DWC finds the MAR is $416.77 for CPT code 97750-GP x 8 units rendered on the disputed date of service.

4. Per the calculations above, in accordance with the applicable DWC Rules, DWC finds that the total MAR amount for all services in this dispute is $820.10.

5. A review of the submitted EOB dated September 6, 2024, finds that the services in dispute have been previously reimbursed in the amount of $810.94. Therefore, no additional reimbursement is recommended.

   DWC finds that the requestor is not entitled to additional reimbursement for the disputed services rendered on March 28, 2024, and April 18, 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 not established that additional reimbursement is due.

Order

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

Authorized Signature:

		November 22, 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.