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

General Information

Requestor Name
Peak Integrated Healthcare

Respondent Name
AIU Insurance Co.

MFDR Tracking Number
M4-25-0044-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 5, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 22, 2024	97110-GP	$360.66	$270.24
July 22, 2024	97112-GP	$138.04	$118.99
	Total	$498.70	$389.23

Requestor's Position

"THIS BILL WAS DENIED AFTER RECONSIDERATIONION STATING THE SAME REASON THAT IT LACKS INFORMATION AND HAS SUBMISSION BILLING ERRORS WHICH IS INCORRECT."

Amount in Dispute: $498.70

Respondent's Position

The Austin carrier representative for AIU Insurance Co. is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on September 10, 2024. Per 28 Texas Administrative Code §133.307 (d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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:

- 16-1 – CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S).
- TX205 - THIS CHARGE WAS DISALLOWED AS ADDITIONAL INFORMATION/DEFINITION IS REQUIRED TO CLARIFY SERVICE/SUPPLY RENDERED.
- TX350 - BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- W3 - IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- XXQB2 - CHARGES HAVE BEEN DENIED FOR MISSING OR INVALID DOCUMENTATION.

Issues

1. Are the insurance carrier's reasons for reimbursement denial of CPT code 97112-GP and 97110-GP supported?

2. Is the requestor entitled to reimbursement?

Findings

1. A review of the submitted explanation of benefits (EOB) finds that the insurance carrier denied reimbursement for CPT code 97110-GP x 6 units and 97112-GP x 2 units, with denial reasons related to lack of information and/or documentation.

   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 The insurance carrier denied reimbursement due to lack of supporting documentation and/or lack of information.

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 97712 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."

Medicare Claims Processing Manual Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services states in pertinent part,

> C. Counting Minutes for Timed Codes in 15 Minute Units
>
> When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed CPT code in the same day measured in 15 minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes, through and including 37 minutes, then 2 units should be billed. Time intervals for 1 through 8 units are as follows:
>
> **Units Number of Minutes**
> 1 unit: ≥ 8 minutes through 22 minutes
> 2 units:≥ 23 minutes through 37 minutes
> 3 units:≥ 38 minutes through 52 minutes
> 4 units:≥ 53 minutes through 67 minutes
> 5 units:≥ 68 minutes through 82 minutes
> 6 units:≥ 83 minutes through 97 minutes…

A review of the submitted medical record finds documentation to support that the services of 6 units of CPT code 97110 and 2 units of CPT code 97112, as described above, were rendered on the disputed date of service.

DWC finds that the insurance carrier's reimbursement denial reason of CPT codes 97110-GP and 97112-GP based on lack of documentation and/or information is not supported.

2. The requestor is seeking reimbursement in the total amount of $498.70 for 6 units of CPT code 97110-GP and 2 units of CPT code 97112 rendered on July 22, 2024.

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 any 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 the disputed date of service in 2024 is 33.2875
- 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.
- The Medicare Participating MPPR amount for CPT code 97110 at locality 11 in 2024, is $22.11 for each unit.
- Using the above formula, DWC finds the MAR is $45.04 per unit.
- Therefore, the MAR for CPT code 97110 x 6 units rendered on the disputed date of service in locality 11 = $270.24.
- The total MAR amount for CPT codes 97112 x 2 units and 97110 x 6 units, rendered on July 22, 2024, in locality 11, is $389.23.
- The insurance carrier paid $0.00.
- Therefore, reimbursement in the total amount of $389.23 is recommended.

DWC finds that reimbursement is due in the amount of $389.23.

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 amount of $389.23.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the services in dispute. It is ordered that AIU Insurance Co. must remit to Peak Integrated Healthcare $389.23 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature:

		December 13, 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.