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
Amco Insurance Co.

MFDR Tracking Number
M4-25-0294-01

Carrier's Austin Representative
Box Number 6

DWC Date Received
October 2, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 29, 2024	97110-GP	$131.71	$0.00
July 29, 2024	97112-GP	$17.07	$0.00
July 30, 2024	97110-GP	$131.71	$0.00
July 30, 2024	97112-GP	$17.07	$0.00
August 2, 2024	97110-GP	$131.71	$0.00
August 2, 2024	97112-GP	$17.07	$0.00
	Total	$446.34	$0.00

Requestor's Position

Excerpt from Request for Reconsideration dated September 5, 2024, and October 2, 2024: "After reconsideration these bills were denied full allowable payment again stating they were processed properly. We disagree and these have not been paid full allowable amount."
Amount in Dispute: $446.34

Respondent's Position

"AMCO stated more specifically on their EOBs that "Physical therapy services were billed with 6 units. Required time is 83 m minutes were documented in the submitted medical record so allowing 5 of 97110 and denied 1 unit of 97110 to disallow the charges…Per the documentation submitted by Peak (attached), the number of therapy units performed was 5. Carrier therefore maintains that the reduction of these bills was in compliance with DWC rules and was appropriate."

Response Submitted by: Stone, Loughlin, Swanson

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 §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:

- P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- P13 - PAYMENT REDUCED OR DENIED BASED ON WORKERS' COMPENSATION JURISDICTIONAL REGULATIONS OR PAYMENT POLICIES.
- W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 193 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

• EOB Comments: "Physical therapy services were billed with 6 units. Required time is 83 minutes. But only 80 minutes were documented in the submitted medical record So allowing 5 unit of 97110 and Denied 1 units of 97110 to disallow the charges. Re-Evaluation may be done upon submission of sufficient medical records supporting the billed code."

Issues

1. Is the insurance carrier's payment reduction reason(s) for CPT code 97110-GP and 97112-GP supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. A review of the explanation of benefits (EOB) documents submitted finds that reimbursement was reduced for the services in dispute based on the application of Workers' Compensation Jurisdictional Payment Policies and Fee Schedule. The insurance carrier's EOB comments specify that one unit of CPT 97110, out of six units billed, was denied due to the minutes of time documented in the medical record.

   On each disputed date of service, the requestor billed six units of CPT code 97110-GP and two units of CPT code 97112-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 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.

   28 TAC §134.203, which applies to the reimbursement of CPT codes 97110 and 97112 in dispute, 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… (c) To determine the maximum allowable reimbursement (MAR) for professional services, system participants shall apply the Medicare payment policies with minimal modifications."

   Medicare Claims Processing Manual Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services, 20.2.C -effective January 1, 2017, titled Reporting of Service Units With HCPCS; Counting Minutes for Timed Codes in 15 Minute Units, states:

   > "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:
   >
   > 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…

The pattern remains the same for treatment times in excess of 2 hours.

If a service represented by a 15 minute timed code is performed in a single day for at least 15 minutes, that service shall be billed for at least one unit. If the service is performed for at least 30 minutes, that service shall be billed for at least two units, etc. It is not appropriate to count all minutes of treatment in a day toward the units for one code if other services were performed for more than 15 minutes."

A review of the submitted documentation finds that on each disputed date of service, the requestor documented 80 minutes spent on therapeutic services represented by CPT code 97110 and documented 25 minutes spent on therapeutic services represented by CPT code 97112. In compliance with the Medicare Claims Processing Manual, 80 minutes of service is to be reported as five units and 25 minutes of service is to be reported as two units.

DWC finds that, in accordance with 28 TAC §134.203, the insurance carrier's reimbursement reduction reason is supported.

2. The requestor is seeking additional reimbursement in the amount of $131.71 for six units of CPT code 97110-GP and in the amount of $17.07 for two units of CPT code 97112 on each disputed date of service.

   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 disputed 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 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.

- MPPR rates are published by carrier and locality.
- Per the medical bills submitted, the disputed services were rendered in zip code 75043, locality 11, Dallas.

For CPT code 97112 x 2 units rendered on July 29, 2024, July 30, 2024, and August 2, 2024:

- The Medicare conversion factor on the disputed dates of service is 33.2875 and the DWC conversion factor is 67.81.
- 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 $67.90 for the first unit and $51.09 for the second unit. Therefore, the MAR for 97112 x 2 units rendered July 29 through August 2, 2024, = $118.99 per date of service.
- The insurance carrier issued payment in the amount of $120.97 for CPT code 97112 per each disputed date of service.
- No additional reimbursement is recommended for CPT code 97112.

For CPT code 97110 x 6 units rendered on July 29, 2024, July 30, 2024, and August 2, 2024:

- The Medicare conversion factor on the disputed dates of service is 33.2875 and the DWC conversion factor is 67.81.
- The Medicare Participating MPPR amount in locality 11 is $22.11 per unit.
- Using the above formula, DWC finds the MAR for 97110 x 5 units rendered July 29 through August 2, 2024, = $225.20 per date of service.
- The insurance carrier issued payment in the amount of $228.95 per each disputed date of service.
- No additional reimbursement is recommended for CPT code 97110.

DWC finds that the requestor is not entitled to additional reimbursement for the services in dispute rendered on July 29, 2024, July 30, 2024, and August 2, 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 additional reimbursement in the amount of $0.00 for the disputed dates of service.

Authorized Signature:

November 5, 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.