



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Peak Integrated  
Healthcare

**Respondent Name**

TASB Risk Management Fund

**MFDR Tracking Number**

M4-25-0429-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

October 22, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 2, 2024	97110-GP	\$120.22	\$0.00
July 2, 2024	98940-GP	\$0.00	\$0.00
July 2, 2024	99080-73	\$0.00	\$0.00
July 2, 2024	99213	\$185.89	\$0.00
July 9, 2024	98940-GP	\$0.00	\$0.00
July 9, 2024	97110-GP	\$120.22	\$0.00
July 11, 2024	98940-GP	\$0.00	\$0.00
July 11, 2024	97110-GP	120.22	\$0.00
<b>Total</b>		<b>\$546.55</b>	<b>\$0.00</b>

### Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of their reconsideration that states, "After reconsideration only the 6/24 date of service was paid correctly, paying on both of the authorized 97110-GP and 98940-GP. These were authorized treatments and should be paid in full."

**Supplemental response January 8, 2025**

"...We have not been paid in full yet."

**Amount in Dispute:** \$546.55

## **Respondent's Position**

"Your request for payment has been re-viewed and the additional payment has processed per the Texas professional fee schedule. CPT 98940-GP previously paid under TSTX-449105 \$56.002, CPT 97110-GP has processed for additional payment of 105.90 under TTX-466786. A total additional payment of \$105.90 has been issued."

**Response submitted by:** TASB

## **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 guidelines for the resolution of medical fee disputes.
2. [28 TAC §134.600](#) sets out the requirements of prior authorization.
3. [28 TAC §134.203](#) sets out the reimbursement guidelines for professional medical services.

### Denial Reasons

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

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 236 – This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the NCCI or workers compensation state regulations/fee schedule requirements.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 351 – No additional reimbursement allowed after review of appeal/reconsideration.

- 435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure.
- 95 – Plan procedures not followed.
- G15 – Pricing is calculated 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 reductions was taken.
- J31 – The therapy service code has been reduced per the Medicare multiple procedure rule for therapy services.
- P12 – Workers’ compensation jurisdictional fee schedule adjustment.
- U00 – There was no UR procedure /treatment request received.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 197 – Precertification/authorization/notification absent.
- 240 – Preauthorization not obtained.

### Issues

1. Are the insurance carrier’s reasons for denial or reduction of payment supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

### Findings

1. The requestor is seeking payment of code 97110 for dates of service July 2, 2024, July 9, 2024 and July 11, 2024 in addition to code 99213 for date of service July 2, 2024. The insurance carrier previously denied code 97110 for these dates of service as not prior authorized. The respondent provided evidence of payments of \$105.90 paid for code 97110 for each disputed date of service. These payments were dated November 7<sup>th</sup> and 8<sup>th</sup>, 2024. The requestor acknowledged payment on January 8, 2025 but wished to continue with MFDR stating, “We have not been paid in full yet.” The applicable fee guideline allowable is shown below.
2. The applicable DWC fee guideline for physical therapy is 28 TAC §134.203 (b) (1) which requires the application of Medicare payment policies applicable to professional services.

The applicable Medicare payment policy is found at [www.cms.gov](http://www.cms.gov), Medicare Claims Processing Manual, Chapter 5, Section 10.7 Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services. *Medicare applies a multiple procedure payment reduction (MPPR) to the practice expense (PE) payment of select therapy services. The reduction applies to the HCPCS codes contained on the list of "always therapy" services (see section 20), excluding A/B MAC (B)-priced, bundled and add-on codes, regardless of the type of provider or supplier that furnishes the services. Medicare applies an MPPR to the PE payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedure*

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

- MPPR rates are published by carrier and locality.
- The services were provided in Dallas, Texas.
- The carrier code for Texas is 4412 and the locality code for Dallas is 11.

The following formula represents the calculation of the DWC MAR at §134.203 (c)(1) & (2).  $\text{DWC Conversion Factor} \div \text{Medicare Conversion Factor} \times \text{Medicare Payment} = \text{MAR}$

- The first unit allowable is \$29.51.  $67.81/33.2875 \times \$29.51 = \$60.11$
- The second unit allowable to which the MPPR reduction applies is \$22.48.  $67.81/33.2875 \times 22.48 = \$45.79$
- Total allowable for each date of service for code 97110 is \$105.90.

Regarding code 99213 the claim was denied per CC1 edits. DWC Rule §134.203 (b)(1) 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."

Review of the applicable CCI edit found 99213 does have an edit with code 98940. The insurance carrier's denial is supported. No payment is recommended.

3. The total allowable DWC fee guideline reimbursement is rate for the code 97110 on dates of service July 2, 9, and 11, 2024 is \$105.90 or \$317.70. The insurance carrier paid \$317.70. No additional payment is recommended.

## **Conclusion**

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has not established payment is due.

**ORDER**

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

**Authorized Signature**

		January 30, 2025
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 in accordance with 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](http://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, please call CompConnection at 1-800-252-7031, option three or email [CompConnection@tdi.texas.gov](mailto: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 tres o correo electronico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).