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

General Information

Requestor Name
Metroplex Adventist Hospital

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-25-1168-01

Carrier's Austin Representative
Box Number 45

DWC Date Received
January 28, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 1, 2024	97116	$44.60	$0.00
March 6, 2024	97112	$50.56	$0.00
March 6, 2024	97530	$72.12	$0.00
March 13, 2024	97530	$72.12	$0.00
March 13, 2024	97112	$50.56	$0.00
March 18, 2024	97112	$66.58	$0.00
March 27, 2024	97116	$44.60	$42.96
March 29, 2024	97112	$50.56	$0.00
March 29, 2024	97530	$72.12	$0.00
	Total	$523.82	$42.96

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a document titled "Reconsideration" that states, "Per EOB received appeal denied for no additional payment due to CTP codes 97112, 97116, and 97530 denied due to procedure codes are inconsistent with the modifier used; or missing modifier. Please note that other DOS were paid using the same modifier GP for PT services."

Amount in Dispute: $523.82

Respondent's Position

"In review of the medical evidence submitted with the dispute request the provider did not provide evidence that the medical bills were submitted to the Office appending the appropriate modifier for the procedure's codes in dispute as outlined in the National Correct Coding Initiative (NCCI) (Exhibit A)."

Response Submitted by: State Office of Risk Management (SORM)

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §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 resolving medical fee disputes.

2. 28 TAC §134.403 sets out the billing guidelines for outpatient physical therapy claims.

Denial Reasons

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

- 97 - The benefit for this service is included in the pymt/allowance for another service/procedure that has already been adjudicated.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Is the insurance carrier's denial supported?

2. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking payment of physical therapy services rendered, March 1, 2024 through March 29, 2024. The insurance carrier denied these services as being packaged in another procedure. DWC Rule 28 TAC §134.403 (d) states, "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided…" Review of the applicable National Correct Coding Initiative Edits found the following.

    - March 1, 2024 – 97116 – Therapeutic procedure, 1 or more areas, each 15 minutes, gait training has an unbundle relationship with 97150 – Therapeutic procedure (s),

group (2 or more individuals). Review of the submitted medical bill found insufficient evidence to support the disputed service was separate and distinct (no modifier). The insurance carrier's denial is upheld. No payment is recommended.

- March 6, 2024 – 97112 – 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. Has an unbundle relationship with 97150 – Therapeutic procedure (s), group (2 or more individuals). Review of the submitted medical bill found insufficient evidence to support the disputed service was separate and distinct (no modifier). The insurance carrier's denial is upheld. No payment is recommended.

- March 6, 2024 – 97530 - Therapeutic activities, direct (one-on-one) patient contact. Has an unbundle relationship with 97150 – Therapeutic procedure (s), group (2 or more individuals). Review of the submitted medical bill found insufficient evidence to support the disputed service was separate and distinct (no modifier). The insurance carrier's denial is upheld. No payment is recommended.

- March 13, 2024 – 97530 – Therapeutic activities, direct (one-on-one) patient contact. Has an unbundle relationship with 97150 – Therapeutic procedure (s), group (2 or more individuals). Review of the submitted medical bill found insufficient evidence to support the disputed service was separate and distinct (no modifier). The insurance carrier's denial is upheld. No payment is recommended.

- March 13, 2024 – 97112 - 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, has an unbundle relationship with 97150 – Therapeutic procedure (s), group (2 or more individuals). Review of the submitted medical bill found insufficient evidence to support the disputed service was separate and distinct (no modifier). The insurance carrier's denial is upheld. No payment is recommended.

- March 18, 2024 – 97112 - 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. Has an unbundle relationship with 97150 – Therapeutic procedure (s), group (2 or more individuals). Review of the submitted medical bill found insufficient evidence to support the disputed service was separate and distinct (no modifier). The insurance carrier's denial is upheld. No payment is recommended.

- March 27, 2024 – 97116 - Therapeutic procedure, 1 or more areas, each 15 minutes. This code was denied as packaged. Review of the submitted medical bill and itemized charges found only codes 97110 -GP, 97112 -GP and 97116 -GP and 97530 -GP which does not result in any NCCI edits. The disputed charge will be reviewed per applicable fee guideline.

- March 29, 2024 – 97112 – 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. Has an unbundle relationship with 97150 – Therapeutic procedure (s), group (2 or more individuals). Review of the submitted medical bill found insufficient evidence to support the disputed service was separate and distinct (no modifier). The insurance carrier's denial is upheld. No payment is recommended.

- March 29, 2024 – 97530 – Therapeutic activities, direct (one-on-one) patient contact has an unbundle relationship with 97150 – Therapeutic procedure (s), group (2 or more individuals). Review of the submitted medical bill found insufficient evidence to support the disputed service was separate and distinct (no modifier). The insurance carrier's denial is upheld. No payment is recommended.

2. As shown above, the denial for code 97116 for dates of service March 26, 2024 was not supported. The disputed service is for therapy rendered in outpatient hospital setting. DWC Rule 28 TAC §134.403 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

   The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.1. Specifically, Payment Status Indicators and Ambulatory Payment Category (APC). The applicable status indicator is "A" which indicates this service is paid per fee schedule other than OPPS.

   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 insurance carrier's reduction of payment is supported.

   28 TAC §134.203 (c)(1) states, "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…"

   Medicare Claims Processing Manual Chapter 5, 10.3.7-effective June 6, 2016, titled Multiple Procedure Payment Reductions 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.

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

The following code was submitted for date of service March 27, 2024

- 97110 has a practice expense of .42
- 97112 has a practice expense of 50
- 97116 has a practice expense of .42
- 97530 has a practice expense of .65

Code 97116 does NOT have the highest ranking practice expense and will be reimbursed at the MPPR reduced rate fee of $21.09.

- The DWC conversion factor for 2024 is 67.81
- The Medicare conversion factor for 2024 is 33.2875.
- MPPR rates are published by carrier and locality.
- Review of the submitted medical claim finds that the services were rendered in zip code 76549; therefore, the Medicare locality is "Rest of Texas."

The following formula represents the calculation of the DWC MAR at §134.203 (c)(1) & (2).

(DWC Conversion Factor ÷ Medicare Conversion Factor) x Medicare Payment = MAR

$67.81/$33.2875 x $21.09 = $42.96

3. The maximum allowable reimbursement (MAR) for the disputed service is $42.96. This amount is recommended.

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 additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that State Office of Risk Management must remit to Metroplex Adventist Hospital $42.96 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

	Medical Fee Dispute Resolution Officer	March 4, 2025
Signature		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, please call CompConnection at 1-800-252-7031, option three 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 tres o correo electronico CompConnection@tdi.texas.gov.