



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Peak Integrated Healthcare

Respondent Name

Hartford Casualty Insurance Company

MFDR Tracking Number

M4-25-1538-01

Carrier's Austin Representative

Box Number 47

DWC Date Received

March 12, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 6, 2025	97110 GP	\$102.90	\$11.65
January 6, 2025	97112 GP	\$19.05	\$2.09
January 8, 2025	97110 GP	\$102.90	\$11.65
January 8, 2025	97112 GP	\$19.05	\$2.09
Total		\$243.90	\$27.48

Requestor's Position

"These bills were denied for 'exceeds unit value or mppr'. This is INCORRECT. We are authorized to treat. Therefore this date of service should be paid in full as all others. We requested authorization for CPT codes 97110 AND 97112 before scheduling treatment."

Amount in Dispute: \$243.90

Respondent's Position

"The original bill for dos 1/6-1/8/25 was received on 1/17/25 and paid as benefit maximum for this time period or occurrence has been reached and also procedure exceeds the unit value and/or the multiple procedure rules. Paid in the amount of \$791.42 under control ... on 1/23/25. Nothing further is owed."

Response Submitted by: The Hartford

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 resolving medical fee disputes.
2. [28 TAC §134.203](#) sets out the fee guideline for professional medical services.
3. [28 TAC §134.600](#) sets out the preauthorization guidelines for specific treatments and services.

Denial Reasons

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

- 119 - Benefit maximum for this time period or occurrence has been reached.
- 133 – The disposition of this claim/service is pending further review.
- 163 - The charge for this procedure exceeds the unit value and/or the multiple procedure rules.
- PPRJ – Paid without prejudice.
- W3 – Bill is a reconsideration or appeal.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 1115 – We find the original review to be accurate and are unable to recommend any additional allowance.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. What are the services in dispute?
2. Is the Insurance Carrier's denial reason(s) supported?
3. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks additional reimbursement for CPT Codes 97110-GP and 97112-GP rendered on January 6, 2025, and January 8, 2025. The insurance carrier reduced the disputed services with reduction codes indicated above.

The requestor seeks additional payment in the amount of \$19.05 for CPT code 97112, and

\$102.90 for CPT code 97110. 28 TAC §134.203 set out the fee guidelines for the reimbursement of the physical therapy services.

2. The insurance carrier issued payments for CPT codes 97110 and 97112 and reduced the remaining charges indicating that the benefit maximum has been reached. .

28 Texas Administrative Code §134.600(p) states, in relevant part:

Non-emergency health care requiring preauthorization includes:

(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:

(A) Level I code range for Physical Medicine and Rehabilitation, but limited to:

- (i) Modalities, both supervised and constant attendance;
- (ii) Therapeutic procedures, excluding work hardening and work conditioning;
- (iii) Orthotics/Prosthetics Management;
- (iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code; and

(B) Level II temporary code(s) for physical and occupational therapy services provided in a home setting;

(C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following:

- (i) the date of injury; or
- (ii) a surgical intervention previously preauthorized by the insurance carrier;

Review of the submitted documentation finds a Preauthorization Determination Letter dated January 21, 2025, that approved CPT codes 97110, and 97112, with a start date of November 18, 2024, and an end date of January 30, 2025. The disputed services were rendered within the preauthorized timeframes.

The Division finds that disputed CPT codes 97110 and 97112 were preauthorized in accordance with 28 Texas Administrative Code §134.600. The insurance carrier's denial reason of "119" is not supported. The requestor is therefore entitled to additional reimbursement for the remaining unpaid units of CPT codes 97110 and 97112.

3. The DWC applies 28 TAC §134.203 to determine if reimbursement was issued in accordance with the medical fee guidelines.

28 TAC §134.203(a)(5) states, "'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."

The requestor billed the following CPT Codes 97710-GP and 97112-GP. The definition of each code is indicated below:

CPT code 97110 - "Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility."

CPT Code 97712 – "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 "GP" modifier to both codes. The "GP" modifier is described as "Services delivered under an outpatient physical therapy plan of care."

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 the 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.

For 2025 the codes subject to MPPR are found in CMS-1784-F the CY 2025 PFS Final Rule

Multiple Procedure Payment Reduction Files. Review of that list finds that CPT Codes 97710-GP and 97112-GP are subject to the MPPR policy.

The chart below outlines the ranking for PE payment for each of the codes billed by the health care provider.

CPT Code	Practice Expense
97110	0.43
97112	0.48

As shown above, CPT Code 97112 has the highest PE payment amount the services billed by the provider that day, therefore, the reduced PE payment applies to all other services.

28 TAC §134.203 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..."

The MPPR Rate File that contains the payments for 2025 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, TX.
- The carrier code for Texas is 4412 and the locality code for Dallas is 11.

CPT Code	Medicare Fee Schedule (1 st unit)	MPPR for subsequent units
97110 x 6		\$22.00
97112 x 2	\$32.27	\$24.45

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

- The 2025 DWC Conversion Factor is 70.18
- The 2025 Medicare Conversion Factor is 32.3465
- Per the medical bills, the services were rendered in Dallas, TX.

Date of Service	CPT Code	# Units	CMS Payment	MAR	Insurance Carrier Paid	Amount Sought	Recommended Amount
January 6, 2025	97110	6	\$22.00	\$47.73 x 6 = \$286.39	\$274.74	\$102.90	\$11.65
January 6, 2025	97112	2	1st Unit \$32.27 2nd Unit \$24.45	1st Unit \$70.01 2nd Unit \$53.05 = \$123.06	\$120.97	\$19.05	\$2.09
January 8, 2025	97110	6	\$22.00	\$47.73 x 6 = \$286.39	\$274.74	\$102.90	\$11.65
January 8, 2025	97112	2	1st Unit \$32.27 2nd Unit \$24.45	1st Unit \$70.01 2nd Unit \$53.05 = \$123.06	\$120.97	\$19.05	\$2.09

Reimbursement of \$27.48 is recommended for dates of service January 6, 2025, and January 8, 2025

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 requester has established that additional reimbursement of \$27.48 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor \$27.48 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

April 4, 2025
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 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 electrónico CompConnection@tdi.texas.gov.