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
Twin City Fire Insurance Co.

MFDR Tracking Number
M4-25-1555-01

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
October 1, 2024	99213	$0.00	$0.00
October 1, 2024	99080	$0.00	$0.00
October 1, 2024	97110-GP	$314.88	$224.46
October 1, 2024	97112-GP	$17.05	$0.00
	Total	$331.93	$224.46

Requestor's Position

Excerpt from the Request for reconsideration dated January 10, 2025: "We requested preauthorization for CPT codes 97110 AND 97112 before scheduling treatment… Please note you approved these 6 sessions of physical therapy PREAUTH #..."

Amount in Dispute: $331.93

Respondent's Position

The Austin carrier representative for Twin City Fire Insurance Co. is Burns, Anderson, Jury & Brenner, L.P. The representative was notified of this medical fee dispute on March 18, 2025. 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 §134.600 sets out the preauthorization guidelines for specific treatments and services.
3. 28 TAC §134.203 set out the fee guidelines for professional medical services.

Adjustment Reasons

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

- 01 – The charge for the procedure exceeds the amount indicated in the fee schedule.
- @F – Additional payment made on appeal/reconsideration.
- APRV – The provider's charges were reviewed with consideration of the Payor's UR/Preauthorization Decision(s) governing this claimant. The listed allowance reflects the results of their decision(s) and all applicable Bill Review Decision(s).
- MZ – The usual treatment session provided in the home or office setting is 30 to 45 minutes. The medical necessity of services for an unusual length of time must be documented. *Note that this reduction code was provided for CPT code 97110 only.
- P12 - Workers' compensation jurisdictional fee schedule adjustment.
- W3 - In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. What services are in dispute?
2. Is the reimbursement reduction reason for CPT code 97110-GP supported?
3. Is the requestor entitled to additional reimbursement for the disputed CPT codes 97112-GP and 97110-GP?

Findings

1. A review of the submitted DWC060 Medical Fee Dispute Resolution Request form finds that procedure codes 97110-GP, 97112-GP, 99213, and 99080 are listed in the table of services in dispute. Per the DWC060 form, the requestor is seeking additional reimbursement in the amount of $0.00 for procedure codes 99213 and 99080. The requestor is seeking additional reimbursement in the amounts of $314.88 and $17.05 for procedure codes 97110-GP and 97112-GP, respectively.

   DWC finds that the only procedure codes in dispute, with an amount greater than $0.00 are 97110-GP and 97112-GP. Therefore, only these codes will be reviewed in this MFDR.

2. A review of the explanation of benefits (EOB) submitted finds that the insurance carrier reduced the reimbursement for six units of CPT code 97110 based on reason code MZ which asserts that "The usual treatment session provided in the home or office setting is 30 to 45 minutes. The medical necessity of services for an unusual length of time must be documented."

   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."

   28 TAC §134.600 which sets out preauthorization guidelines for specific treatments and services, states in pertinent part, "(p) 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… "

   Furthermore, 28 TAC 134.600(l) states, "(l) <u>The insurance carrier shall not withdraw a preauthorization or concurrent utilization review approval once issued</u>. The approval shall include:

   (1) the specific health care;

(2) the approved number of health care treatments and specific period of time to complete the treatments;

(3) a notice of any unresolved dispute regarding the denial of compensability or liability or an unresolved dispute of extent of or relatedness to the compensable injury; and

(4) the insurance carrier's preauthorization approval number that conforms to the standards described in §19.2009(a)(4) of this title (relating to Notice of Determinations Made in Utilization Review)."

A review of the submitted documents finds a utilization review determination letter dated September 24, 2024, authorizing six sessions of physical therapy to be provided between the dates of September 24, 2024, and March 24, 2025. A review of the preauthorization determination letter finds no mention of limited minutes or units of service allowed per physical therapy session.

A review of the submitted medical record finds that the medical documentation supports that on October 1, 2024, the requestor rendered six units (88 minutes) of procedure code 97110 as defined above. Therefore, DWC finds that the insurance carrier's reimbursement reduction reason of six units of CPT code 97110 is not supported.

DWC finds that in accordance with 28 TAC §134.600, the services in dispute were billed and rendered as preauthorized. Because DWC Rule 28 TAC §134.600(l) prohibits the insurance carrier from withdrawing preauthorization once it has been issued, DWC finds that the insurance carrier's reimbursement reduction reason of six units of CPT code 97110 is not supported.

3. The requestor is seeking additional reimbursement for CPT code 97112-GP in the amount of $17.05 and for CPT code 97110-GP in the amount of $314.88, for a total reimbursement amount of $331.93.

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.

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." 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.

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 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.

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

DWC finds that the MPPR discounting rule applies to the services in dispute.

Of the services in dispute, 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 timed therapy codes performed on the same date of service.

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..."

DWC finds that on the disputed date of service, the requester billed for and documented the rendering of two units of CPT code 97112 and six units of CPT code 97110. The MAR is calculated as follows:

- MPPR rates are published by carrier and locality.
- Per the medical bills, the services were rendered in zip code 75211; 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 2024B Medicare Conversion Factor for the disputed date of service is 33.2875.

For CPT code 97112

- 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.
- DWC finds that the MAR for 2 units of 97112 on the disputed date of service in locality 11 is $118.99.
- The insurance carrier paid $120.95.
- No additional reimbursement is recommended for CPT code 97112-GP rendered on October 1, 2024.

For CPT code 97110

- The Medicare Participating MPPR discount amount for CPT code 97110 at locality 11 in 2024 is $22.11.
- Using the above formula, DWC finds the MAR for CPT code 97110 x 6 units rendered on the disputed date of service = $270.24.
- The insurance carrier paid $45.78.
- Additional reimbursement is recommended in the amount of $224.46 for CPT code 97110-GP rendered on October 1, 2024.

DWC finds that CPT 97110 is the only disputed code for which an additional amount is due. DWC finds that the requestor is entitled to additional reimbursement in the amount of $224.46 for disputed CPT code 97110-GP rendered on October 1, 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 established that additional reimbursement is due in the amount of $224.46 for CPT code 97110-GP rendered on October 1, 2024.

Order

Under Texas Labor Code §§413.031 and 413.019, the Division of Workers' Compensation has determined that the requestor is entitled to additional reimbursement. Therefore, it is hereby ordered that Twin Cities Fire Insurance Co. must remit the amount of $224.46, plus any applicable accrued interest, to Peak Integrated Healthcare within 30 days of receiving this order, in accordance with 28 TAC §134.130.

Authorized Signature:

		May 21, 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 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.