SOAH Docket No. 454-24-06559 **Suffix: M4_NP**

BEFORE THE STATE OFFICE OF ADMINISTRATIVE HEARINGS

KAMLA KNIGHT, DC,
PETITIONER
V.
LIBERTY MUTUAL INSURANCE CORPORATION,
RESPONDENT

DECISION AND ORDER

This case involves physical therapy services rendered by Kamla Knight, DC (Provider) to an injured employee (Patient) covered by the workers' compensation system. The Texas Department of Insurance, Division of Workers' Compensation (Division) conducted a medical fee dispute resolution (MFDR) and declined to order Liberty Mutual Insurance Corporation (Carrier) to reimburse Provider in the amount of $8,645.00 for services provided to Patient. The Administrative Law Judge (ALJ) finds that Provider demonstrated that the some of the services provided to Patient are reimbursable. Therefore, the ALJ concludes that Provider is entitled to reimbursement in the amount of $6,705.00.

I. NOTICE, JURISDICTION, AND PROCEDURAL HISTORY

There are no contested issues of notice or jurisdiction; therefore, those matters are addressed solely in the Findings of Fact and Conclusions of Law.

On January 11, 2023, the Division received Provider's request for a MFDR.[1] Carrier filed a response to the MFDR request, arguing that Provider did not bill with the needed modifiers for provided services.[2] On September 15, 2023, the Division issued its decision and concluded that Provider was not entitled to the reimbursement sought.[3] Provider requested a hearing at the State Office of Administrative Hearings (SOAH) to contest the Division's decision. On December 5, 2023, the Division issued a Request to Docket letter that, when combined with the ALJ's order setting the hearing, issued January 10, 2024, served as a notice of hearing.

On February 27, 2024, SOAH ALJ Megan Johnson convened a hearing on the merits via Zoom videoconference. Provider appeared and represented herself. Carrier appeared through its attorney, John Fundis. The record closed on February 28, 2024, with the filing of the admitted exhibits.

[1] Resp. Ex. 1 at 3.

[2] Resp. Ex. 1 at 4.

[3] Resp. Ex. 1 at 9.

II. APPLICABLE LAW

The resolution of a medical fee dispute is regulated by the Division's billing, audit, and payment rules.[4] Providers must submit bills to a carrier within 95 days of the date of service.[5] If the carrier denies or pays a reduced amount for the medical services rendered to an injured employee, the health care provider is entitled to review—an MFDR—by the Division.[6] In these cases, the Division adjudicates the payment due for services determined to be medically necessary and appropriate pursuant to the relevant statutory provisions and the Division's rules.[7]

A party requesting an MFDR must timely file it with the Division or it waives its right to MFDR.[8] Such request must be filed no later than one year after the date(s) of service in dispute.[9] Additionally, the requestor must provide documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with 28 Texas Administrative Code section 134.1 when the dispute involves health care for which the Division has not established a maximum allowable reimbursement or reimbursement rate, as applicable.[10] Moreover, "for coding, billing, reporting, and reimbursement of

---

[4] *See* 28 Tex. Admin. Code (TAC) ch. 133. All citations in this Decision and Order reflect the law applicable on the date of service for each claim.

[5] Tex. Labor Code § 408.027(a).

[6] Tex. Labor Code § 413.031(a); 28 TAC § 133.307(b)(1).

[7] Tex. Labor Code § 413.031(c); 28 TAC § 133.307(a)(2).

[8] 28 TAC § 133.307(c)(1).

[9] 28 TAC § 133.307(c)(1)(A). Provider did not assert an exception under 28 TAC § 133.307(c)(1)(B).

[10] 28 TAC § 133.307(c)(2)(O).

medical services, Texas workers' compensation system participants shall apply . . . Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; [and] modifiers . . . ."[11] Finally, a Work Status Report filed successfully can be reimbursed at $15.00 and requires such a reimbursement request to be billed as "CPT Code '99080' with modifier '73.'"[12]

Health care providers must include billing codes from the appliable Division fee guidelines in effect on the date(s) of service when submitting medical bills.[13] A provider may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier.[14] Moreover, the carrier may request additional medical documentation or, within 30 days of receipt of an incomplete bill, contact the provider to obtain information necessary to make the bill complete.[15] However, the carrier shall complete the bill by adding missing information already known to the carrier, except for, among other things, procedure or modifier codes.[16] When returning a bill, the carrier shall include a document identifying the reason(s) for returning the bill, including identification of the procedure or modifier code(s) by

[11] 28 TAC § 134.203(b)(1). "Medicare payment policies" means 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. 28 TAC § 134.203(a)(5).

[12] 28 TAC § 129.5(j)(1). There are other situations, inapplicable to this case, that require the doctor bill with a different or additional modifier. 28 TAC § 129.5(j)(2)-(3).

[13] 28 TAC § 133.20(c)

[14] 28 TAC § 133.20(g).

[15] *See* 28 TAC §§ 133.20(h); .200(a)(2), (3).

[16] 28 TAC § 133.200(a)(2)(A)(ii).

line item.[17]

If a dispute remains after an MFDR review, a party may request a contested case hearing at SOAH.[18] As the party requesting a hearing at SOAH to challenge an adverse medical fee dispute decision, Provider has the burden of proof to show by a preponderance of the evidence that Provider is entitled to reimbursement.[19]

The hearing before SOAH is a de novo review of the issues involved.[20] A trial de novo review has "all the attributes of an original action in the reviewing court" where the "court must weigh the evidence by the 'preponderance of the evidence' standard."[21] It is not an "appeal" but is a "new and independent action."[22]

---

[17] 28 TAC § 133.200(b).

[18] Tex. Labor Code § 413.0312(e).

[19] 28 TAC § 148.14(b), (e).

[20] *See Vista Med. Ctr. Hosp. v. Tex. Mut. Ins. Co.*, 416 S.W.3d 11, 17-18 (Tex. App.—Austin 2013, no pet.).

[21] *See Key Western Life Ins. Co. v. State Bd. Of Ins.*, 350 S.W.2d 839, 846 (Tex. 1961) (discussing a trial de novo in a district court review of an agency decision when statutorily authorized); *see, e.g.*, Tex. Gov't Code § 2001.173 (describing trial de novo, as "try[ing] each issue . . . as though there had not been an intervening agency action or decision").

[22] *Id.*

III. EVIDENCE

At the hearing, Provider offered 23 exhibits, which were admitted,[23] and Provider testified. Carrier offered one exhibit, which was admitted.[24]

A. BACKGROUND AND BILLING HISTORY

Provider is a physical therapist who treated Patient from January 10, 2022, through April 27, 2022. She is claiming that she is owed a balance of $8,645.00 for these services.[25] Provider had treated Patient prior to 2022 through private insurance, and Patient requested Provider be approved by Carrier as an out-of-network provider through the worker's compensation program, which was accomplished, when Patient was not seeing results from his treatment with his original workers'-compensation-approved provider.[26] After numerous visits and two further approvals for treatment, Provider completed treatment of Patient on April 27, 2022, and sent her bills for about $11,000.00 to Carrier on May 2, 2022.[27]

---

[23] Provider's admitted exhibits are as follows: Ex. 1 (1/6/22 email from Joshua Lariva); Ex. 2 (1/27/22 email from Jessica Campos); Ex. 3 (2/25/22 email from Jessica Campos); Ex. 4 (5/13/22 email from Andrea Aman); Ex. 5 (fax log and bills); Ex. 6 (5/17/22 Letter request for HCFA form); Ex. 7 (July 2022 EOBs); Ex. 8 (8/18/22 email from Jarrod Roof); Ex. 9 (August 2022 EOBs); Ex. 10 (September 2022 EOBs); Ex. 11 (Novitas fee schedule); Ex. 12 (11/7/22 Dispute/Appeal); Ex. 13 (December 2022 EOBs); Ex. 14 (MFDR Request); Ex. 15 (1/30/23 Letter from Carol Mendoza); Ex. 16 (MFDR Decision); Ex. 17 (9/23 corrected claims resubmission); Ex. 18 (September 2023 EOBs); Ex. 19 (October 2023 EOBs); Ex. 20 (Benefit Review Conference Report); Ex. 21 (Knight Wellness Collection policy and Auto Accident 100% Reimbursement).

[24] Carrier Ex. 1 (MFDR File).

[25] Carrier Ex. 1.

[26] Provider Testimony.

[27] Provider Testimony.

Provider made numerous calls to Carrier's original adjuster, Andrea Aman, to confirm receipt of the bills. Provider also faxed[28] and mailed her bills and Health Care Financing Administration (HCFA) forms to Carrier. On June 22, 2022, Patient told Provider that the case was assigned to a new adjuster, Jared Roof. Provider contacted Mr. Roof about the status of the bills and payment, and he referred her to Carrier's Billing Department.[29] Carrier processed the bills, and Provider eventually received two payments for services—one for $500.00 and the other for $2,092.28.[30]

Provider contacted Mr. Roof to inquire about why she was not reimbursed for the approximately $11,000.00 billed.[31] Mr. Roof again referred her to the Carrier's Billing Department. Provider called the Billing Department on more than one occasion and would spend three to five hours on the phone with them attempting to figure out what she needed to do, and which CPT codes should be used.[32] In turn, the Billing Department referred Provider to Mr. Roof for those answers.[33]

Provider then contacted the Texas Department of Insurance (TDI) to ask what resources were available to her. TDI referred to her Mr. Roof and said that, if he could not help, she needed to contact his supervisor.[34] Provider then spoke to

[28] Provider Ex. 5.

[29] Provider Ex. 8.

[30] Provider Testimony.

[31] Provider Testimony.

[32] Provider Testimony.

[33] Provider Testimony.

[34] Provider Testimony.

Mr. Roof's supervisor, Melanie McCarthy-Dickey, who said that she could not help her.[35] Provider again called TDI and they instructed her to go to the Novitas website for coding information.[36] Provider researched Novitas and updated her bills with all of the codes from Novitas.[37] Provider maintains that Novitas showed the codes she billed without a modifier as "reimbursable."[38]

Provider then called TDI about the next steps, and a representative told her she could file an appeal and dispute with Carrier within ten months of a Patient's visit.[39] Provider submitted a modified bill to Carrier through an appeal and dispute on November 7, 2022 (Patient's first visit was on January 10, 2022, and, therefore, the ten-month deadline was on November 10, 2022).[40] On December 5, 2022, Provider received a response from Carrier indicating that it received the appeal past the 10-month deadline and would not be taking any action with regards to dates of service between January 10 and 19, 2022.[41]

[35] Provider Testimony.

[36] Provider Testimony.

[37] Provider Ex. 11.

[38] Provider Testimony.

[39] Provider Testimony. *See* 28 TAC § 133.250(b).

[40] Provider Ex. 12.

[41] Provider Ex. 13.

B. MFDR

On January 18, 2023, Provider submitted a request for MFDR.[42] The disputed services as reflected in the MFDR Findings and Decision[43] were:

Dates of Service	Disputed Services
1/10/22	G0283-59, 97110-59, 97112-59, 99204-25
1/11/22	99080
1/12/22	G0283-59, 97110-59, 97112-59, 97012-59
1/14/22	G0283-59, 97110-59, 97112-59, 97012-59
1/17/22	G0283-59, 97110-59, 97112-59, 97012-59
1/19—2/16/22	G0283-59, 97110-59, 97112-59, 97012-59
1/31—3/30/22	G0283, 97110-59, 97112-59, 97012-59
1/26/22	G0283-59, 97110-59, 97112-59, 97012
2/2/22	G0283, 97110-59, 97112-59, 97012, E0730
3/7/22	G0283, 97110-59, 97112-59, 97012, 97530-59
3/23/22	G0283-59, 97110-59, 97112-59, 97012
4/11/23 [sic]	G0283, 97110-59, 97112-59, 9701[sic]-59, 99214-25
4/27/22	G0283, 97110-59, 97112-59, 97012-59

Two weeks later, Provider received a letter from Carol Mendoza with Carrier's Billing Department in response to a health care network complaint by Provider pursuant to 28 Texas Administrative Code section 10.121.[44] This letter

[42] Provider Ex. 14.

[43] Carrier Ex. 1 at 1.

[44] Provider. Ex. 15.

confirmed that Carrier approved payment for dates of service outside the 95-day filing rule. The letter also indicated that the therapy codes submitted were re-reviewed and denied correctly because Provider did not bill with the necessary modifiers for those services. Ms. Mendoza then attached a Novitas printout with the Therapy Modifiers needed for Provider's billing. The letter then stated that a "request for reconsideration with the needed modifiers has not been submitted by the provider" and indicated that Provider may file a complaint with TDI if she is dissatisfied with the resolution.[45]

Provider then contacted TDI about the letter and inquired as to her options. Greg Errant at TDI informed her that the modifiers provided in the letter are correct but, because she had already filed a MFDR, she cannot go back and change the bills.[46] Mr. Errant told Provider that an MFDR decision takes about 45-60 days; Provider did not receive a decision until September 13, 2023 (270 days later).

Provider requested review of services provided January 10—April 27, 2022, with an amount in dispute of $8,645.00. Both Provider and Carrier submitted their positions, and the decision was, in summary, as follows:

1. *Did the insurance carrier maintain a denial for 95-day timely filing?* The denials made for the 95-day timely filing were not maintained, and, therefore, those services were reviewed pursuant to the applicable rules and guidelines.

[45] Provider Ex. 15.

[46] Provider Testimony.

2. *Is CPT code 99204-25 separately payable?* CPT codes 98941, 98943, G0283-59, 97710-59, 97710-59, and 97112-59 billed on January 10, 2022, also had services 99204-25 with a CCI edit with codes 98941 and 98943 billed on the same day. Review of the documentation does not support the use of the modifier "-25" and denial was supported.

3. *Did the requestor append the appropriate modifier when billing for physical therapy services?* A modifier of "GP" was required for CPT codes 97110-59, 97012-59, G0283-59, 97112-59, and 97530-59. Because this modifier was not used, reimbursement was not recommended.

4. *What modifier is required when billing for a work status report?* A mandatory modifier of "-73" was not used with CPT code 99080 on date of service January 11, 2022. Because this necessary modifier was not included, the denial was supported.

5. *Is the requestor entitled to reimbursement for the DME charge?* Code E0790 for date of service of February 2, 2022, was reduced to reflect the fee schedule allowance and, as such, no additional reimbursement was recommended.

6. *Is the requestor entitled to reimbursement for the services in dispute?* The Division found that Provider did not establish any reimbursement was due.[47]

Just over a week after receiving the MFDR decision, on September 21, 2023, Provider resubmitted her bills to Carrier with corrected CPS codes and modifiers (Corrected Bill).[48] This appeal was denied because it was received past the 10-month

[47] Carrier Ex. 1.

[48] Provider Testimony.

time frame (from the date of service) for reconsideration of payment (Corrected Bill EOB).[49]

Provider again contacted TDI and was told that the next step was to request a Benefit Review Conference, which Provider did. The Conference was conducted on November 6, 2023; however, issues remained unresolved.[50] The corresponding letter informed Provider of her right to appeal with SOAH.

IV. ANALYSIS

The preponderance of the evidence before the ALJ shows the Provider is owed an additional reimbursement in the amount of $6,705.00. The applicable statutory scheme "impliedly delegates to the Division, and, in turn, to SOAH, exclusive jurisdiction to determine the amount of medical reimbursement that is owed by a carrier to a health care provider under the [workers' compensation] act and the Division's rules, subject to judicial review under the [Administrative Procedures Act] substantial-evidence standard."[51] These statutes afford an aggrieved party a right to a de novo hearing at SOAH on the reimbursement refund claim, where the final administrative order is rendered.[52] Thus, the ALJ considered all admitted evidence in determining the amount of reimbursement owed to Provider, if any.

[49] Provider Ex. 18.

[50] Provider Testimony; Provider Ex. 20.

[51] *Vista Med. Ctr. Hosp. v. Tex. Mut. Ins. Co.*, 416 S.W.3d 11, 18 (Tex. App.—Austin 2013, no pet.).

[52] *Id.* at 17-18.

The evidence demonstrates that Provider was diligent in her efforts to bill timely and correctly under the applicable workers' compensation reimbursement statutes and rules. She consistently contacted Carrier's adjuster and billing department and TDI regarding the procedures and billing requirements. Carrier reimbursed Provider $2,592.28 in two separate payments—a fraction of the approximately $11,000 billed. After appeals for reimbursement to the Carrier, Provider eventually requested, and received, an MFDR by the Division, which resulted in no additional reimbursement.

While the MFDR was pending, Provider received information from Carrier's Billing Department regarding the correct modifiers for her bills. She inquired with TDI about submitting revised bills with the required modifiers but was advised that she could not re-file anything at that time because she had already requested the MFDR. After receiving the MFDR decision, Provider submitted the Corrected Bills, which were subsequently denied as either late under the 95-day deadline (from date of service) or reviewed on a previously submitted bill/currently in process, as reflected on the Corrected Bill EOB.[53]

As outlined above, the issue before the ALJ is the amount of medical reimbursement that is owed to Provider, if any, under the applicable statutes and rules. The CPT codes for dates of service disputed in the MFDR were, except for a handful, denied for failing to include a necessary modifier of "GP," which indicates the services were delivered under an outpatient physical therapy plan of care. There

[53] Provider Exs. 17, 19.

was no argument or evidence presented that these CPT codes *with* the modifier "GP" would *not* have been payable, had the modifier been included on the original bill submission.

The Division's billing rules allow a carrier to return a bill as incomplete when it fails to include all required fields, including modifier codes.[54] If her bills were returned, Provider would have had the opportunity to correct and resubmit a new bill with the modifiers.[55] Carrier chose not to do so here. Instead, Carrier processed the bills as complete and set the course for Provider's options regarding appeal. By doing so, Carrier effectively concluded that the additional detail gleaned from the modifiers were not necessary to evaluate the submitted bills. This conclusion is supported by the evidence that the therapy codes are reimbursable procedures that Provider performed. Nothing suggests that the modifier affects this determination. Further, the evidence establishes the correct modifier, which resolves any ambiguity as to the entitlement of reimbursement. In the simple terms, if the modifier mattered, Carrier had a process to resolve it. It chose not to and now argues that it should be allowed to use its decision to deny Provider's reimbursement, despite that the evidence shows the correct CPT codes were submitted, the correct modifier codes have now been received, and Provider's services are reimbursable. The ALJ declines to accept Carrier's argument in this regard.

---

[54] 28 TAC §§ 133.2(4), .200(a)(2)(A)(ii), (3). This decision to return the bill in reinforced in the Claims Processing Manual, which instructs a contractor to return—not deny—a claim that does not contain a modifier. Claims Processing Manual, Chapter 5, Section 20.1—Discipline Specific Outpatient Rehabilitation Modifiers—All claims, *available at* www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c05.pdf; *see also* Claims Processing Manual, Chapter 1, Section 60.1—General Information on Non-covered Charges on Institutional Claims (detailing that returned claim may be corrected and resubmitted where denied claims cannot be resubmitted), *available at* www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c01.pdf.

[55] 28 TAC § 133.20(g).

Because the evidence demonstrates that Provider would have been entitled to reimbursement for the disputed services given the CPT codes that were originally submitted and with the modifiers, the ALJ concludes that Provider is entitled to reimbursement as follows:

1. **95-day deadline**: The ALJ agrees with the MFDR decision. The denials made for 95-day timely filing were not maintained by Carrier, and the disputed services were reviewed pursuant to applicable rules and guidelines.

2. **CPT code 99204-25**: The parties did not present any evidence regarding whether CPT code 99204-25 is separately payable. Therefore, Provider did not meet her burden and no reimbursement is due.

3. **Modifiers for physical therapy services**: The MFDR decision concluded that a modifier of "GP" was necessary for the disputed physical therapy services (CPT codes 97110, 97012, G0283, 97112, 97530). Provider provided the correct modifier as evidence in this de novo proceeding and included the "GP" modifier on her Corrected Bills. There is no dispute that the services as billed with the modifier would be reimbursable. Therefore, reimbursement is due for these CPT codes as follows:

Date of Service	Disputed Service CPT Code	Amount Due
1/10/22	97110; G0283; 97112	$210
1/12/22	97110; 97012; G0283; 97112	$285
1/14/22	97110; 97012; G0283; 97112	$285
1/17/22	97110; 97012; G0283; 97112	$285
1/19/22	97110; 97012; G0283; 97112	$285
1/21/22	97110; 97012; G0283; 97112	$285
1/24/22	97110; 97012; G0283; 97112	$285
1/26/22	97110; 97012; G0283; 97112	$285

1/28/22	97110; G0283; 97112	$210
1/31/22	97110; 97012; G0283; 97112	$285
2/2/22	97110; 97012; G0283; 97112	$285
2/14/22	97110; 97012; G0283; 97112	$285
2/16/22	97110; 97012; G0283; 97112	$285
2/18/22	97110; 97012; G0283; 97112	$285
2/23/22	97110; 97012; G0283; 97112	$285
2/25/22	97110; 97012; G0283; 97112	$285
3/2/22	97110; 97012; G0283; 97112	$285
3/7/22	97110; 97012; G0283; 97112; 97530	$360
3/11/22	97110; 97012; G0283; 97112	$285
3/16/22	97110; 97012; G0283; 97112	$285
3/23/22	97110; 97012; G0283; 97112	$285
3/30/22	97110; 97012; G0283; 97112	$285
4/11/22	97110; G0283; 97112	$210
4/27/22	97110; 97530; G0283; 97112	$285
	Total:	**$6,690.00**

4. **Modifier for work status report**: The MFDR decision concluded that a billing modifier of "-73" was mandatory when billing for a work status report (CPT code 99080). This modifier has been identified and provided and, for the reasons identified above, the ALJ finds that Provider is entitled to reimbursement on this service. Therefore, reimbursement of $15.00 is due for CPT code 99080.[56]

[56] *See* 28 TAC § 129.5(j)(1).

5. **DME charge**: Provider did not present any evidence to dispute the MFDR finding that the applicable fee guideline allowable amount was paid by Carrier or that any additional reimbursement is owed.

In sum, a preponderance of the evidence demonstrates the Provider is owed an additional reimbursement in the amount of $6,705.00. The ALJ makes the following Findings of Fact and Conclusions of Law in support of this decision.

V. FINDINGS OF FACT

1. Kamla Knight, DC (Provider) performed physical therapy services for an injured worker (Patient) covered by the workers' compensation insurance system from January 10 through April 27, 2022.

2. Liberty Mutual Insurance Corporation (Carrier) was the responsible workers' compensation insurer for Patient.

3. On May 2, 2022, Provider sent her bills totaling approximately $11,000 for performed services to Carrier. She also faxed and mailed her bills and Health Care Financing Administration (HCFA) forms to Carrier.

4. Carrier did not request Provider to provide information necessary to make her submitted bills complete, despite them not including modifiers, which Carrier contended were necessary to determine reimbursement.

5. Provider received two payments from Carrier for $500.00 and $2,092.28.

6. Provider appealed Carrier's decision not to reimburse in the full amount on November 7, 2022, and was denied additional reimbursement.

7. Provider submitted a request for Medical Fee Dispute Resolution (MFDR) with the Texas Department of Insurance (Department), Division of Workers' Compensation, Medical Review Division (Division) on January 18, 2023, for services provided to Patient. Provider requested reimbursement of $8,645.00.

8. On January 30, 2023, Provider received a letter from Carrier's Billing Department regarding her appeal with Carrier. This letter confirmed that the Carrier's case manager gave retroactive approval for payment of dates of service submitted past the 95-day filing rule. The letter also provided the necessary modifiers for Provider's billed services.

9. Provider contacted the Department regarding Carrier's letter. A representative at the Department confirmed the accuracy of the modifiers.

10. The Division issued the MFDR decision on September 13, 2023, finding that Provider had failed to support her position that additional reimbursement was due.

11. On September 21, 2023, Provider resubmitted her bills to Carrier with corrected CPT codes and modifiers. Her appeal was denied because it was received past the ten-month time frame (from the date of service) for reconsideration of payment.

12. Provider then requested, and received, a Benefit Review Conference, which resulted in "unresolved issues."

13. The MFDR decision concluded that the modifier "GP" was necessary for the disputed physical therapy services (CPT codes 97110, 97012, G0283, 97112, 97530). Provider modified these codes for all dates of service to include the "GP" modifier on her Corrected Bills (as reflected on the Corrected Bills EOB).

14. The MFDR decision concluded that the billing modifier "-73" was mandatory when billing for a work status report (CPT code 99080). Provider modified this code for the dates of service of January 11, 2022, to include the "-73" modifier on her Corrected Bills (as reflected on the Corrected Bills EOB).

15. Provider submitted the correct CPT codes for the disputed services.

16. Provider timely requested a hearing before the State Office of Administrative Hearings (SOAH) to contest the Division's determination.

17. On December 4, 2023, the Division provided timely notice of the request to docket case to assign an Administrative Law Judge at SOAH for the hearing.

18. The notice of hearing, together with the ALJ's Order Scheduling Hearing on the Merits, included a statement of the time, place, and nature of the hearing; statements of the legal authority and jurisdiction under which the hearing was to be held; references to the particular sections of the statutes and rules involved; and attachments that incorporated, by reference, the factual matters asserted in the complains or petitions filed with the state agency.

19. The hearing on the merits was held via Zoom videoconference on February 27, 2024, before SOAH ALJ Megan Johnson. Provider appeared and represented herself. Carrier appeared and was represented by attorney John Fundis. The record closed on February 28, 2024, with the filing of the admitted exhibits.

20. The denials made for 95-day timely filing were not maintained by Carrier, and the disputed services were reviewed pursuant to applicable rules and guidelines.

21. The CPT codes for the disputed services are reimbursable at the following rates/amounts:

CPT Code	Amount of reimbursement
97110	$90.00
97012	$75.00
G0283	$30.00
97112	$90.00
97530	$75.00

22. The disputed services are reimbursable in the following amounts:

Date of Service	Disputed Service CPT Code(s)	Amount Due
1/10/22	97110; G0283; 97112	$210
1/11/22	99080-73	$15
1/12/22	97110; 97012; G0283; 97112	$285
1/14/22	97110; 97012; G0283; 97112	$285
1/17/22	97110; 97012; G0283; 97112	$285
1/19/22	97110; 97012; G0283; 97112	$285
1/21/22	97110; 97012; G0283; 97112	$285
1/24/22	97110; 97012; G0283; 97112	$285
1/26/22	97110; 97012; G0283; 97112	$285
1/28/22	97110; G0283; 97112	$210
1/31/22	97110; 97012; G0283; 97112	$285
2/2/22	97110; 97012; G0283; 97112	$285
2/14/22	97110; 97012; G0283; 97112	$285
2/16/22	97110; 97012; G0283; 97112	$285
2/18/22	97110; 97012; G0283; 97112	$285
2/23/22	97110; 97012; G0283; 97112	$285
2/25/22	97110; 97012; G0283; 97112	$285
3/2/22	97110; 97012; G0283; 97112	$285
3/7/22	97110; 97012; G0283; 97112; 97530	$360
3/11/22	97110; 97012; G0283; 97112	$285
3/16/22	97110; 97012; G0283; 97112	$285
3/23/22	97110; 97012; G0283; 97112	$285

3/30/22	97110; 97012; G0283; 97112	$285
4/11/22	97110; G0283; 97112	$210
4/27/22	97110; 97530; G0283; 97112	$285
	Total:	**$6,705.00**

23. Reimbursement is not due for CPT code 99204-25.

24. No additional reimbursement is due relating to the DME charge.

VI. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order. Tex. Labor Code §§ 413.031, .0312(e); Tex. Gov't Code ch. 2003.

2. The hearing before SOAH is a de novo review of the issues involved. *See Vista Med. Ctr. Hosp. v. Texas Mut. Ins. Co.*, 416 S.W.3d 11, 17-18 (Tex. App.—Austin 2013, no pet.).

3. Adequate and timely notice of the hearing was provided to the parties. Tex. Gov't Code §§ 2001.051-.052.

4. For coding, billing, reporting, and reimbursement of medical services, Texas workers' compensation system participants shall apply Medicare payment policies, including code and modifiers. 28 Tex. Admin. Code § 134.203(b)(1).

5. If a health care provider is denied or paid a reduced amount for the medical services rendered to an injured employee, the provider is entitled to review—an MFDR—by the Division. Tex. Labor Code § 413.031(a).

6. If a dispute remains after the MFDR review, a party may request a contested case hearing at SOAH. Tex. Labor Code § 413.0312(e).

7. Provider has the burden of proof to show by a preponderance of the evidence that it is entitled to reimbursement. 28 Tex. Admin. Code § 148.14(b), (e).

8. Provider is entitled to reimbursement in the amount of $6,705.00, plus any applicable interest.

VII. ORDER

It is **ORDERED** that Liberty Mutual Insurance Corporation is required to pay the sum of $6,705.00, plus applicable interest, to Kamla Knight, DC for the services at issue in this case.

VIII. NONPREVAILING PARTY DETERMINATION

Texas Labor Code section 413.0312(g) and 28 Texas Administrative Code section 133.307(h) require the nonprevailing party to reimburse the Division for the cost of services provided by SOAH. Texas Labor Code section 413.0312(i) requires SOAH to identify the nonprevailing party and any costs for services provided by SOAH in its final decision. For purposes of Texas Labor Code section 413.0312, Liberty Mutual Insurance Corporation is the nonprevailing party. The costs associated with this decision are set forth in Attachment A to this Decision and Order and are incorporated herein for all purposes.

Signed April 23, 2024.

ALJ Signature:

MEGAN JOHNSON
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS