TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION DISMISSAL

Requestor Name
UT Health East Texas Rehabilitation

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-20-1608-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
February 25, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The bill and appeal were denied based on the diagnosis used. The diagnosis code is correct and verified by the billing office."

Amount in Dispute: $1,105.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Furthermore, the use of (redacted diagnosis) do not clearly point that treatment is being rendered for the compensable injury."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
September 4 – 30, 2019	Physical Therapy	$1,105.85	$993.95

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets out the general Medical Dispute Resolution guidelines.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedure for Medical Dispute Resolution of Medical Necessity Disputes.
4. 28 Texas Administrative Code §133.240 sets out requirements for denial of claims.
5. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
6. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - B22 – This payment is adjusted based on the diagnosis

Issues

1. Is the insurance carrier's denial comply with DWC rules?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to additional payment?

Findings

1. The requestor is seeking additional reimbursement for outpatient therapy services performed in September 2019. The carrier denied the services based on the submitted diagnosis. The insurance carrier stated in their position statement the treatment being rendered was not for the compensable injury.

   Review of the documentation submitted by the parties finds that the carrier did not provide documentation to support that a Plain Language Notice (PLN) regarding the disputed condition as required by 28 TAC §133.307(d)(2)(H) had been presented to the requestor or that the requestor had otherwise been informed of PLN prior to the date that the request for medical fee dispute resolution was filed with the Division.

   Because the compensability of the diagnosis denial was not timely presented to the requestor in the manner required by 28 TAC §133.240 the disputed services will be reviewed per the applicable DWC rules and fee guidelines.

2. 28 TAC §134.403 applies to outpatient hospital services. Section (h) requires when Medicare reimburses using other Medicare fee schedules, reimbursement is made using the applicable Division Fee Guideline in effect for that service on the date was provided.

   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 Medicare 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.

   The MPPR policy allows for full payment for the unit or procedure with the highest PE payment factor and for subsequent units the PE payment factor is reduced by 50 percent.

   Review of the submitted medical bill provided indicates that three procedures were billed by the health care provider. In order to determine the MPPR allowable, the services provided are ranked by their PE expense shown below.

Code	Practice Expense	Allowed Amount	Medicare Policy
97022	0.33	$11.99	MPPR applies
97035	0.17	$10.73	MPPR applies
97110	0.4	$30.31/$23.55	Highest PE First unit paid in full. Additional units MPPR applies
97140	0.35	$21.70	MPPR applies

The *MPPR Rate File* that contains the payments for 2019 services is found at www.cms.gov

- MPPR rates are published by carrier and locality.
- The services were provided Tyler, Texas.
- The carrier code for Texas is 4412 and the locality code for Tyler is 99.

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

Applicable 28 TAC 134.203(h) states that the total reimbursement is the lesser of the maximum allowable reimbursement (MAR) and the billed amount.

Date of Service	Code	Units	Medicare Payment	DWC Conversion Factor divided by Medicare Conversion Factor or 59.19 ÷ 36.0391 = 1.64	Billed Amount	Lesser of MAR and billed amount
September 4, 2019	97022	1	$11.99	$11.99 x 1.64 = $19.66	$156.00	$19.66
September 6, 2019	97022	1	$11.99	$11.99 x 1.64 = $19.66	$156.00	$19.66
September 9, 2019	97022	1	$11.99	$11.99 x 1.64 = $19.66	$156.00	$19.66
September 16, 2019	97022	1	$11.99	$11.99 x 1.64 = $19.66	$156.00	$19.66
September 18, 2019	97022	1	$11.99	$11.99 x 1.64 = $19.66	$156.00	$19.66
September 23, 2019	97022	1	$11.99	$11.99 x 1.64 = $19.66	$156.00	$19.66
September 27, 2019	97022	1	$11.99	$11.99 x 1.64 = $19.66	$156.00	$19.66
September 30, 2019	97022	1	$11.99	$11.99 x 1.64 = $19.66	$156.00	$19.66
September 16, 2019	97035	1	$10.73	$10.73 x 1.64 = $17.60	$136.00	$17.60
September 18, 2019	97035	1	$10.73	$10.73 x 1.64 = $17.60	$136.00	$17.60
September 4, 2019	97110	3	$30.31 1st unit $23.55 Additional	$30.31 x 1.64 = $49.71 $23.55 x 1.64 x 2 = $77.24	$584.25	$126.95
September 6, 2019	97110	2	$30.31 $23.55	$30.31 x 1.64 = $49.71 $23.55 x 1.64 = $38.62	$389.50	$88.33
September 9, 2019	97110	2	$30.31 $23.55	$30.31 x 1.64 = $49.71 $23.55 x 1.64 = $38.62	$389.50	$88.33
September 16, 2019	97110	1	$30.31	$30.31 x 1.64 = $49.71	$194.75	$49.71
September 18, 2019	97110	2	$30.31 $23.55	$30.31 x 1.64 = $49.71 $23.55 x 1.64 = $38.62	$389.50	$88.33
September 23, 2019	97110	3	$30.31 1st unit $23.55 Additional	$30.31 x 1.64 = $49.71 $23.55 x 1.64 x 2 = $77.24	$584.25	$126.95
September 27, 2019	97110	3	$30.31 1st unit $23.55 Additional	$30.31 x 1.64 = $49.71 $23.55 x 1.64 x 2 = $77.24	$584.25	$126.95
September 30, 2019	97110	2	$30.31 $23.55	$30.31 x 1.64 = $49.71 $23.55 x 1.64 = $38.62	$389.50	$88.33

September 16, 2019	97140	1	$21.70	$21.70 x 1.64 = $35.59	$159.75	$35.59
					Total	$993.95

3. The total allowable DWC fee guideline reimbursement is $993.95. This amount 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 established payment is due. As a result, the amount ordered is $993.95.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $993.95, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

_____	_____	May 29, 2020
Signature	Medical 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 Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.