



# TEXAS DEPARTMENT OF INSURANCE

## Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

UT Health East Texas Rehab

**Respondent Name**

Redwood Fire & Casualty Ins Co Rfcic

**MFDR Tracking Number**

M4-20-2467-01

**Carrier's Austin Representative**

Box Number 6

**MFDR Date Received**

June 10, 2020

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "This bill and appeal have been underpaid."

**Amount in Dispute:** \$327.27

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Once the time sheets are received, payment will be processed."

**Response Submitted by:** Berkshire Hathaway

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 19 – 28, 2020	Outpatient Therapy Services	\$327.27	\$0.00

#### FINDINGS AND DECISION

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

#### **Background**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - Additional payment made on appeal/reconsideration
  - The charge for the procedure exceeds the amount indicated in the fee schedule

- Workers' compensation jurisdictional fee schedule adjustment
- Documentation submitted does not substantiate the service billed (97530 2 units)

**Issues**

1. Is the carrier's reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

**Findings**

1. The requestor is seeking additional reimbursement for outpatient therapy services performed in February 2020. The carrier reduced the allowed amount based on the workers compensation fee schedule and documentation does not substantiate the billed services. Review of the submitted documentation did not find sufficient evidence to support that more than one unit of code 97110 and 97530 were provided on the dates of service in dispute. The insurance carrier's reduction in number of units is supported.
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 Practice Expense (PE) payment factor and for subsequent units the Practice Expense (PE) payment factor is reduced by 50 percent.

Review of the submitted medical bill provided indicates that two 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
97110	0.4	\$23.57	MPPR reduction applies
97530	0.66	\$38.93/\$27.66	Full payment first unit, MPPR applies to second unit

The *MPPR Rate File* that contains the payments for 2019 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 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).

$$(DWC\ Conversion\ Factor \div Medicare\ Conversion\ Factor) \times Medicare\ Payment = MAR$$

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	Unit	Medicare Payment	DWC Conversion Factor divided by Medicare Conversion Factor or $\$60.32 \div 36.0896$	Billed Amount	Lesser of MAR and billed amount
February 19, 2020	97110	1	\$23.57	\$39.39	\$389.50	\$39.39
February 21, 2020	97110	1	\$23.57	\$39.39	\$194.75	\$39.39
February 24, 2020	97110	1	\$23.57	\$39.39	\$194.75	\$39.39
February 26, 2020	97110	1	\$23.57	\$39.39	\$194.75	\$39.39
February 28, 2020	97110	1	\$23.57	\$39.39	\$194.75	\$39.39
February 19, 2020	97530	1	\$38.93	\$65.07	\$468.00	\$65.07
February 21, 2020	97530	1	\$38.93	\$65.07	\$468.00	\$65.07
February 24, 2020	97530	1	\$38.93	\$65.07	\$468.00	\$65.07
February 26, 2020	97530	1	\$38.93	\$65.07	\$468.00	\$65.07
February 28, 2020	97530	1	\$38.93	\$65.07	\$468.00	\$65.07
Total						\$522.30

3. The total allowable DWC fee guideline reimbursement is 522.30. The insurance carrier paid \$520.97. No additional payment 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 not established payment is due. The amount ordered is \$0.00.

***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
Date

October 5, 2020

## ***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.**