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
American Zurich Insurance Co

MFDR Tracking Number
M4-21-0767-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 12, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This therapy bill has been underpaid."

Amount in Dispute: $489.37

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…the Provider was not entitled reimbursement for CPT code 97530 when the Provider had already been reimbursed for other CPT codes."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 1 – 27, 2020	Outpatient Therapy Services	$489.37	$414.28

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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 231 – Mutually exclusive procedures cannot be done on the same day/setting
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

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 October 2020. The carrier reduced the allowed amount based on the workers compensation fee schedule and mutually exclusive procedures.

   Although the DWC adopts Medicare payment policies by reference in Rule §134.203, paragraph (a)(7) of that rule states that specific provisions contained in the Division of Workers' Compensation rules shall take precedence over any conflicting provision adopted the Medicare program.

   MUE's were implemented by Medicare to set a maximum number of units for a specific service that a provider would report under most circumstances for a single patient on a single date of service thus detecting potentially medically unnecessary services.

   The Medicare MUE payment policy is in direct conflict with Texas Labor Code §413.014 which requires that all determinations of medical necessity shall be made prospectively or retrospective through utilization review; and with Rule §134.600 which sets out the procedures for preauthorization and retrospective review of professional services such as those in dispute here. The DWC concludes that Labor Code §413.014 and 28 TAC §134.600 take precedence over Medicare MUE's; therefore, the respondent's denial reasons are not supported. The services in dispute will be reviewed per applicable 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 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 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
97035	0.19	11.07	MPPR Applies
97140	0.35	22.00	MPPR Applies
97530	0.66	38.93 27.66	No MPPR 1st unit MPPR applies 2nd unit

The *MPPR Rate File* that contains the payments for 2020 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 ÷ 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 60.32 / 36.0896	Billed Amount	Lesser of MAR and billed amount
October 1, 2020	97530	1	$38.93	$65.07	$234.00	$65.07
October 8, 2020	97530	2	$66.59	$111.30	$468.00	$111.30
October 9, 2020	97530	2	$66.59	$111.30	$468.00	$111.30
October 12, 2020	97530	2	$66.59	$111.30	$468.00	$111.30
October 26, 2020	97530	2	$66.59	$111.30	$468.00	$111.30
October 27, 2020	97530	2	$66.59	$111.30	$468.00	$111.30
October 1, 2020	97035	1	$11.07	$18.50	$136.00	$18.50
October 8, 2020	97035	1	$11.07	$18.50	$136.00	$18.50
October 12, 2020	97035	1	$11.07	$18.50	$136.00	$18.50
October 26, 2020	97035	1	$11.07	$18.50	$136.00	$18.50
October 27, 2020	97035	1	$11.07	$18.50	$136.00	$18.50
October 1, 2020	97140	1	$22.00	$36.77	$159.75	$36.77
October 9, 2020	97140	1	$22.00	$36.77	$159.75	$36.77
October 12, 2020	97140	1	$22.00	$36.77	$159.75	$36.77
October 26, 2020	97140	1	$22.00	$36.77	$159.75	$36.77
October 27, 2020	97140	1	$22.00	$36.77	$159.75	$36.77
					Total	$897.72

2. The total allowable DWC fee guideline reimbursement is $897.92 the insurance carrier paid $483.64. The balance of $414.28 is due to the requestor.

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. The amount ordered is $414.28.

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 $414.28 plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

		February 23, 2021
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 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.