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
Texas Health Fort Worth

Respondent Name
Sompo America Insurance Co

MFDR Tracking Number
M4-21-1355-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 5, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These services were authorized and that was proven in our appeal with the authorization letter."

Amount in Dispute: $393.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Austin carrier representative for Sompo America Insurance Co is Flahive Ogden & Latson who was notified of this medical fee dispute on April 13, 2021. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

As of today, no response has been received from the carrier or its representative. This decision is based on the information available as authorized under §133.307(d)(1).

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 1 – 16, 2020	Outpatient Therapy Services	$393.80	$376.34

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:
   - 197 – Payment denied/reduced for absence of precertification/authorization

Issues

1. Is the carrier's denial of payment supported?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for outpatient therapy services performed in September 2020. The carrier denied the services based on lack of prior authorization. Review of the submitted documentation found correspondence dated August 13, 2020, that authorized 10 visits from July 17, 2020 to October 17, 2020. Insufficient evidence was submitted by the insurance carrier to support their denial. 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 occupational 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
97110	0.4	$24.04	MPPR applies
97537	0.43	$33.36/$25.67	MPPR does not apply to first unit does apply to second 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 Fort Worth, Texas
   - The carrier code for Texas is 4412 and the locality code for Fort Worth is 28.

   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 = 1.67	Billed Amount	Lesser of MAR and billed amount
September 1, 2020	97110	1	$24.04	$40.18	$169.00	$40.18
September 2, 2020	97110	1	$24.04	$40.18	$169.00	$40.18
September 16, 2020	97110					Not in dispute
September 1, 2020	97537	2	33.36 1st 25.67 2nd	$55.76 $42.90	$616.50	$98.66
September 2, 2020	97537	2	33.36 1st 25.67 2nd	$55.76 $42.90	$616.50	$98.66
September 16, 2020	97537	2	33.36 1st 25.67 2nd	$55.76 $42.90	$616.50	$98.66
					Total	$376.34

2. The total DWC fee guideline reimbursement is $376.34. 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. The amount ordered is $376.34.

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 $376.34, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 17, 2021 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.