TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
UT Health East Texas Rehab

Respondent Name
Great Divide Insurance Co

MFDR Tracking Number
M4-22-0505-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
November 9, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 2, 2021	Physical Therapy	$270.57	$0.00
	Total	$270.57	$0.00

Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states, "Underpaid/Denied Therapy. Please review for 10 units. Not paid per the fee schedule."

Amount in Dispute: $270.57

Respondent's Position

The bill was paid correctly according to the TX WC and the CMS guidelines.

Response Submitted by: Berkley Environmental

Findings and Decision

Authority

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

Statutes and Rules

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.

Denial Reasons

The insurance carrier [reduced or denied] the payment for the disputed services with the following claim adjustment codes:

- 356 – This outpatient allowance was based on the Medicare's methodology (Part B) plus the Texas Markup
- 650 – Allowance is reduced per the multiple procedure payment reductions for selected therapy services
- P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Is Insurance Carrier's reduction based on multiple procedure reduction and fee schedule supported?

2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for outpatient therapy services performed in September 2021. The carrier reduced the allowed amount based on the workers compensation fee schedule and multiple procedure payment rules.

   DWC Rule 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 insurance carrier's reduction of payment is supported.

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 one procedure for 10 units was billed by the health care provider. To determine the MPPR allowable, the services provided are ranked by their PE expense shown below.

Code	Practice Expense	Allowed Amount	Medicare Policy
97750	0.52	$33.44	2nd – 10th unit $24.77

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 ÷ 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 61.17 ÷ 34.8931 = 1..75	Billed Amount	Lesser of MAR and billed amount
September 2, 2021	97750	1 9	$33.44 $24.77	$58.62 $390.81	$2727.50	$449.43
					Total	$449.43

2. The total allowable DWC fee guideline reimbursement is $449.43. The insurance carrier paid $449.43. No additional payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor

and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 6, 2021 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

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

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.