TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
ELISA MIRANDA PT

Respondent Name
ARCH INDEMNITY INSURANCE COMPANY

MFDR Tracking Number
M4-22-0534-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
November 12, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 18, 2020 through November 30, 2020	97110 x 3 and 97140 x 2	$960.36	$0.00
	Total	$960.36	$0.00

Requestor's Position

"Insurance carrier was sent medical bills in a timely manner. The insurance carrier, Helmsman, provided EOBs in return, denying payment on the claims. Provider's representative re-sent the bills for reconsideration. No reimbursements have been made on the enclosed medical bills."

Amount in Dispute: $960.36

Respondent's Supplemental Position

"...the carrier has reprocessed the provider's bill. We are attaching a copy of the EOBs. For the November 18th, 2020 and November 30th, 2020 dates of service, the carrier has recommended reimbursement of $393.25 plus interest in the amount of $9.92. For the November 19th, 2020 date of service, the carrier has recommended reimbursement of $215.87 plus interest in the amount of $5.45."

Response Submitted by: Flahive, Ogden & Latson

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 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §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:

- 5882 – Pre-Authorization was requested but denied for this service per DWC Rule 134.600
- 10 – The billed service requires the use of a modifier code
- U301 – This item has been reviewed on a previously submitted bill, or is currently in process
- 309 – The charge for this procedure exceeds the fee schedule allowance
- 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules

Issues

1. Did the insurance carrier issue payment for the services in dispute in accordance with 28 TAC §134.203?
2. Is the Requestor entitled additional to reimbursement?

Findings

1. The requestor seeks reimbursement for medical services rendered on November 18, 2020 through November 30, 2020. The insurance carrier states in the supplemental position summary dated January 3, 2022, the following, "…the carrier has reprocessed the provider's bill. We are attaching a copy of the EOBs. For the November 18th, 2020 and November 30th, 2020 dates of service, the carrier has recommended reimbursement of $393.25 plus interest in the amount of $9.92. for the November 19th, 2020 date of service, the carrier has recommended reimbursement of $215.87 plus interest in the amount of $5.45."

   The DWC finds that the insurance carrier submitted a copy of the EOB in support of payment and therefore, no longer seeks resolution based on the denial reasons indicated above. As a result, the DWC will calculate the MAR amount to determine if the correct payment was issued for the services in dispute.

2. TAC §134.203 (c)(1)(2) states in pertinent part, "To determine the Maximum Allowable Reimbursement (MAR) for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in

paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors and shall be effective January 1st of the new calendar year. ..."

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:

CPT Code	Practice Expense	Medicare Policy
97110	0.4	Highest rank, no MPPR for first unit
97140	0.35	MPPR applies

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 Pasadena, Texas
- The Locality is Houston
- The 2020 DWC Conversion Factor is 60.32
- The 2020 Medicare Conversion Factor is 36.0896

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.

DOS	CPT CODE	# UNITS	AMOUNT PAID	MAR	MAR - Amount Paid = Amount Due	DISPUTED AMOUNT	AMOUNT DUE
11/18/20	97110	4	$177.38	$50.83 first unit $42.19 for 3 units = $177.39	$177.39 - $177.38 = $0.00	$277.04	$0.00
11/18/20	97140	1	$38.49	$38.49	$38.49 - $38.49 = $0.00	$64.62	$0.00
11/19/20	97110	4	$177.38	$50.83 first unit $42.19 for 3 units = $177.39	$177.39 - $177.38 = $0.00	$277.04	$0.00
11/19/20	97140	1	$38.49	$38.49	$38.49 - $38.49 = $0.00	$64.62	$0.00
11/30/20	97110	4	$177.38	$50.83 first unit $42.19 for 3 units = $177.39	$177.39 - $177.38 = $0.00	277.04	$0.00
TOTAL			$609.12	$609.15	$0.00	$960.36	$0.00

Per 28 TAC §134.203 (h)(1-2), "…When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; (3) fair and reasonable amount consistent with the standards of §134.1 of this title." The DWC finds that the requestor is therefore, entitled to a total recommended amount of $0.00.

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.

The DWC finds the requester has not established that additional reimbursement is due.

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

		January 13, 2022
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 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.