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

General Information

Requestor Name
Wadley Regional Medical Center

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-22-1082-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
November 16, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 4 – 21, 2021	Rev Codes 420-424	$45.23	$0.00
	Total	$45.23	$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."

Amount in Dispute: $45.23

Respondent's Position

Our position is that no payment is due.

Response Submitted by: Texas Mutual

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 the payment for the disputed services with the following claim adjustment codes:

- P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 284 – No allowance was recommended as this procedure has a Medicare status of B (bundled)
- 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 reduction for selected therapy services

Issues

1. Is the insurance carrier's reduction supported?

2. Is requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for outpatient therapy services performed in January 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 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	29.44/22.77	MPPR applies
97112	0.49	34.18/26.02	No MPPR highest PE on date of service Additional units MPPR applied
97116	0.4	29.44/22.77	MPPR applies
97140	0.35	27.07/21.24	MPPR applies
97162	1.33	99.07	No MPPR highest PE on date of service

The *MPPR Rate File* that contains the payments for 2021 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 Texarkana Texas.
- The carrier code for Texas is 4412 and the locality code for Texarkana 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

January 20,2021	97010	1	$0.00	Non-covered service	$108.89	$0.00
January 21,2021	97010	1	$0.00	Non-covered service	$108.89	$0.00
January 21,2021	97110	1	$22.77	$39.92	$114.43	$39.92
January 6, 2021	97112	3	59.92 1st unit 45.61 2nd & 3rd units	$151.15	$349.80	$151.15
January 13, 2021	97112	3	59.92 1st unit 45.61 2nd & 3rd units	$151.15	$349.80	$151.15
January 20, 2021	97112	3	59.92 1st unit 45.61 2nd & 3rd units	$151.15	$349.80	$151.15
January 21, 2021	97112	2	59.92 1st 45.61 2nd	$105.53	$233.20	$105.53
January 6, 2021	97116	1	22.77	$39.92	$82.62	$39.92
January 13, 2021	97116	1	22.77	$39.92	$82.62	$39.92
January 20,2021	97140	1	21.24	$37.24	$121.61	$37.24
January 4, 2021	97162	1	99.07	$173.68	$332.48	$173.68
					Total	$889.66

2. The total allowable DWC fee guideline IS $889.66. The insurance carrier paid $889.66. 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 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

Signature	Medical Fee Dispute Resolution Officer	February 14, 2022 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.