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

General Information

Requestor Name
Peak Integrated Healthcare

Respondent Name
Old Republic Insurance Co

MFDR Tracking Number
M4-22-2010-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
May 13, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 29. 2021	97110-GP	$330.42	$248.23
December 29. 2021	97112-GP	$128.08	$110.04
	Total	$458.50	$358.27

Requestor's Position

The requestor did not submit a position statement with this request for MFDR.

Amount in Dispute: $458.50

Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed."

Response Submitted by: Gallagher Bassett

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 §134.600 sets out the requirements of prior authorization.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 119 – Benefit maximum for this time period or occurrence has been reached
- 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules
- 247 – A payment or denial has already been recommended for this procedure.

Issues

1. Is the insurance carrier's denial supported?

2. What rule(s) are applicable to reimbursement of disputed services?

3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for physical therapy services rendered in December 2021. The carrier denied the charges as benefit maximum exceeded.

   Review of the documents submitted with the request for MFDR found a "Notice of Review Outcome Approval" dated December 9, 2021. The requested treatment/service that was approved was 12 sessions 97110 x6 and 97112 x6 with a Start date of December 8, 2021 and an end date of March 9, 2022. Insufficient evidence was found to support the insurance carrier's denial of benefits exceeded or unit value exceeded. The insurance carrier's denial is not supported. The disputed service will be reviewed per applicable fee guideline.

2. 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
97110	0.4	$23.60	Not the highest MPPR applies
97112	0.49	$35.77 / $27.00	No MPPR on first unit, MPPR on additional unit on same date of service

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 Garland, Texas.
- The carrier code for Texas is 4412 and the locality code for Garland is 11.

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
December 29, 2021	97110	6	$23.60	$41.37 x 6 = $248.23	$330.42	$248.23
December 29, 2021	97112	2	$35.77 $27.00	$62.71 + 47.33 = $110.04	$128.08	$110.04
					Total	$358.27

2. The total DWC fee guideline reimbursement is $358.27. This amount 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 established that reimbursement of $358.27 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Old Republic Insurance Co must remit to Peak Integrated Healthcare $358.27 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		September 9, 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.