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

General Information

Requestor Name
Christopher Wayne Turner

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-23-0665-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
November 16, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 17, 2021	97750	$981.60	$246.90
	Total	$981.60	$246.90

Requestor's Position

"The claim was billed per Medical Fee Guideline conversion factors as established in Rule 134.203 (c) (2). The DWC Division Ratio/conversation {sic} factors for the date of service billed are utilized for this claim. We have calculated the appropriate Mar by utilizing the CMS Centers for Medicare and Medicaid Services as per the above and as per the attached formula and print outs from the CMS website."

Amount in Dispute: $981.60

Respondent's Position

"Rational: Billed charge $981.60. The charge was already processed, and payment status shows STOP AGED. Allowed amount - $491.68 Payment Date – 03/04/2022."

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 TAC §137.100 sets out the appropriate administrative process for the carrier to retrospectively review.
3. 28 Texas Administrative Code §134.204 sets out the reimbursement guidelines for FCEs.
4. 28 TAC §19.2003 defines retrospective review.
5. 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:

- 5405 – This charge was reviewed through the clinical validation program
- 90201 – Services not documented in patients' medical records
- 5405 – This charge was reviewed through the clinical validation program
- 5875 – Clinical validation reduction based upon review of documentation submitted
- 5920 – Fee Schedule manually priced at billed charge

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for physical therapy services performed in November 2021. The carrier reduced the allowed amount based on the services not documented in the chart and clinical validation program.

   The division notes that DWC Rule 28 TAC §137.100 (e) sets out the appropriate administrative process for the carrier to retrospectively review reasonableness and medical necessity of care already provided. Section (e) states:

"An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017."

Retrospective review is defined in DWC Rule 28 TAC §19.2003 (28) as "The process of reviewing health care which has been provided to the injured employee under the Texas Workers' Compensation Act to determine if the health care was medically reasonable and necessary."

DWC Rule 28 TAC §19.2015(b) titled Retrospective Review of Medical Necessity states: (b) When retrospective review results in an adverse determination or denial of payment, the utilization review agent shall notify the health care providers of the opportunity to appeal the determination through the appeal process as outlined in Chapter 133, Subchapter D of this title (relating to Dispute and Audit of Bills by Insurance Carriers)."

The division finds that the carrier failed to follow the appropriate administrative process to address the assertions made in its response to this medical fee dispute.

DWC Rule 28 TAC §134.204(g) states in pertinent part, FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required. The respondent failed to indicate how the documentation was lacking. The disputed service will be reviewed per applicable reimbursement guideline.

2. DWC Rule 28 TAC §134.203 (c) (1) states in pertinent part, to determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. 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 yearly conversion factor of disputed services. The applicable Medicare payment policy for physical therapy is Multiple Procedure Payment Reduction (MPPR). The insurance carrier's reduction 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 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 Dallas, Texas.
   - The carrier code for Texas is 4412 and the locality code for Dallas 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

- 61.17/34.8931 x 35.06 = $61.46 first unit
- 61.17/34.8931 x 25.75 x 15 = $677.12
- Total MAR $738.58

3. The total allowable DWC fee guideline reimbursement is $738.58. The insurance carrier paid $491.68. Additional payment of $246.90 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 that additional reimbursement 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 Indemnity Insurance Co of North America must remit to Christopher Wayne Turner $246.90 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		April 14, 2023
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 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.

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