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
Zurich American Insurance Co

MFDR Tracking Number
M4-23-0744-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
November 23, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 19, 2022	97750-GP	$502.08	$385.44
	Total	$502.08	$385.44

Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states, "This has been denied after billing and a reconsideration stating "benefit maximum has been reached" and "multiple procedure rules." This is incorrect. The patient has had only one other PPE for this injury. And we have received no payment for this date of service."

Amount in Dispute: $502.08

Respondent's Position

The Austin carrier representative for [Respondent] is [Representative]. The representative was notified of this medical fee dispute on [Date].

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its

decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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 guidelines for the resolution of medical fee disputes.
2. 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:

- 112 – Service not furnished directly to the patient and/or not documented
- 119 – Benefit maximum for this time period or occurrence has been reached
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

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 May 2022. The carrier denied the disputed services as not furnished directly to the patient and/or not documented and benefit maximum for this time period or occurrence has been reached.

   Review of the submitted evaluation indicates a two hour test was done on May 19, 2022 on the injured worker that details the testing performed. The denial of services not documented is not supported.

Insufficient evidence was found to support the insurance carrier's denial as benefit maximum met. The services in dispute will be reviewed per applicable fee guideline discussed below.

2. The applicable DWC fee guideline for physical therapy is 28 TAC §134.203. Section (b) (1) 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.

   The *MPPR Rate File* that contains the payments for 2022 services is found at www.cms.gov.

   - 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.

   - The MPPR rate is $34.77 for the first unit and $25.54 for units two through eight.
   - 62.46/34.6062 x $34.77 = $62.76
   - 62.46/34.6062 x 25.54 = $322.68
   - Total MAR = $385.44

3. The total allowable DWC fee guideline reimbursement is $385.44. This amount 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 payment is due. The amount ordered is $385.44.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to additional reimbursement for the services in dispute. It is ordered that Zurich American Insurance Co must remit to Peak Integrated Healthcare $385.44 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		April 21, 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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