

## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

St Joseph Medical Center

**Respondent Name**

Montgomery County

**MFDR Tracking Number**

M4-23-0805-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

December 1, 2022

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 1 – 23, 2021	Physical Therapy	\$1,512.64	\$919.63
	<b>Total</b>	\$1,512.64	\$919.63

### Requestor's Position

"This bill has been denied for timely filing. I have attached multiple fax confirmations showing proof of timely filing."

**Amount in Dispute:** \$1,512.64

### Respondent's Position

"Specifically, pursuant to section 408.027 of the Texas labor code and division rule 133.20(b), the provider must submit its medical bill to the carrier within 95 days of the date of service. The provider failed to do so. Accordingly, the provider is not entitled to reimbursement."

**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 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the claim submission requirements of medical claims.
3. 28 Texas Administrative Code §102.4 sets out the guidelines of General Rules for Non-Division Communication.
4. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
5. 28 Texas Administrative Code §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:

- 29 – The time limit for filing has expired
- 4271 – Per TX Labor Code SEC 408.027, providers must submit bills to payors within 95 days of the date of service
- 18 – Exact duplicate claim/service

## Issues

1. Did the requestor support timely submission of medical bills?
2. What rule is applicable to reimbursement of disputed charges?
3. Is requestor entitled to additional reimbursement?

## Findings

1. The requestor is seeking additional reimbursement for outpatient therapy services performed in December 2021. The carrier denied the disputed charges as claim not submitted timely.

The requestor submitted evidence of a successful fax sent on March 14, 2022, to 713-957-8510 which is the fax number for the linked insurance carrier, AS&G Administration.

DWC Rule 28 Texas Administrative Code §102.4 (h)(1) states in pertinent part unless the great weight of evidence indicates otherwise, written communications will be deemed to have been sent on the date received if sent by fax, personal delivery, or electronic transmission.

DWC Rule 133.20(b) states in pertinent part, except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.

Based on the applicable rules the disputed services from December 1, through December 7, 2021, are after the 95<sup>th</sup> day. The insurance carrier’s denial is supported.

Dates of service December 9, 2021, through December 23, 2021, will be reviewed per applicable fee guideline.

2. 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 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	31.19/24.01	First unit MPPR does not apply additional units MPPR applies
97140	0.35	28.68/22.40	MPPR applies
97164	1	71.73/53.78	Highest MPPR does not apply

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 Houston, Texas.
- The carrier code for Texas is 4412 and the locality code for Houston is 18.

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 16, 2021	97010	1	\$0.00		\$56.71	\$0.00
December 9, 2021	97110	3	31.19 24.01	$\$31.19 \times 1.75 = \$54.68$ $\$24.01 \times 1.72 \times 2 = \$84.18$	\$1033.56	\$138.86
December 14, 2021	97110	3	31.19 24.01	$\$31.19 \times 1.75 = \$54.68$ $\$24.01 \times 1.72 \times 2 = \$84.18$	\$1033.56	\$138.86
December 16, 2021	97110	2	31.19 24.01	$\$31.19 \times 1.75 = \$54.68$ $\$24.01 \times 1.75 = \$42.09$	\$689.04	\$96.77
December 21, 2021	97110	3	31.19 24.01	$\$31.19 \times 1.75 = \$54.68$ $\$24.01 \times 1.72 \times 2 = \$84.18$	\$1033.56	\$138.86
December 23, 2021	97110	2	\$24.01	$\$24.01 \times 1.75 \times 2 = \$84.18$	\$689.04	\$84.18
December 9, 2021	97140	1	\$22.40	$\$22.40 \times 1.75 = \$39.27$	\$377.12	\$39.27
December 14, 2021	97140	1	\$22.40	$\$22.40 \times 1.75 = \$39.27$	\$377.12	\$39.27
December 16, 2021	97140	1	\$22.40	$\$22.40 \times 1.75 = \$39.27$	\$377.12	\$39.27
December 21, 2021	97140	1	\$22.40	$\$22.40 \times 1.75 = \$39.27$	\$377.12	\$39.27
December 23, 2021	97140	1	\$22.40	$\$22.40 \times 1.75 = \$39.27$	\$377.12	\$39.27
December 23, 2021	97164	1	\$71.73	$\$71.73 \times 1.75 = \$125.75$	\$376.03	\$125.75
Total						\$919.63

2. The total allowable DWC fee guideline reimbursement is \$919.63. 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 additional reimbursement of \$919.63 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 respondent must remit to requestor \$919.63 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

### Authorized Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

January 3, 2023  
\_\_\_\_\_  
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](http://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](mailto: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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).