



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Peak Integrated
Healthcare

Respondent Name

Everest National Insurance Co

MFDR Tracking Number

M4-23-1076-01

Carrier's Austin Representative

Box Number19

DWC Date Received

January 10, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 20, 2022	97750-GP	\$502.08	\$385.44
Total		\$502.08	\$385.44

Requestor's Position

The requestor did not submit a position statement with this request for MFDR but did submit a copy of their reconsideration request that states, "This date of service was denied payment stating, "benefit maximum has been reached, or exceeds unit value or mppr rules. Then based on extent of injury which is incorrect. See attached payment for office visit with same codes has been paid."

Amount in Dispute: \$502.08

Respondent's Position

The Austin carrier representative for Everest National Ins Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on January 18, 2023.

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 the time period or occurrence has been reached
- 163 – The charge for this procedure exceeds the limit value and/or the multiple procedure rules
- 219 – Based on extent of injury

Issues

1. Does the submitted documentation support extent of injury notification?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. What is the rule applicable to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. DWC Rule 28 TAC §133.307(d)(2)(H) requires that if the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with Rule §124.2 (relating to carrier reporting and notification requirements).

DWC Rule 28 TAC §124.2(h) requires notification to the division and claimant of any dispute of disability or extent of injury using plain language notices with language and content prescribed by the division. Such notices “shall provide a full and complete statement describing the carrier's action and its reason(s) for such action. The statement must contain sufficient claim-specific substantive information to enable the employee/legal beneficiary to understand the carrier's position or action taken on the claim.”

Review of the submitted information finds no copies, as required by Rule §133.307(d)(2)(H), of any PLN-11 or PLN 1 notices issued in accordance with Rule §124.2. The insurance carrier’s denial reason is therefore not supported. Furthermore, because the respondent failed to meet the requirements of Rule §133.307(d)(2)(H) regarding notice of issues of extent of injury, the respondent has waived the right to raise such issues during dispute resolution.

Consequently, the division concludes there are no outstanding issues of compensability, extent, or liability for the injury. The disputed services are therefore reviewed pursuant to the applicable rules and guidelines.

2. The requestor is seeking additional reimbursement for Code 97750 – “Physical performance test conducted by healthcare providers to evaluate patients’ physical capabilities.”

The carrier denied the service based on benefit maximum and exceeding the unit value and multiple procedure rules.

Review of the submitted documentation found insufficient evidence to support the denials issued by the insurance carrier. The service in dispute will be reviewed per applicable DWC fee guideline(s),

3. 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.

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

- 62.46/34.6062 x \$34.77 first unit = \$62.76
- 62.46/34.6062 x \$25.54 second through eighth unit = \$322.68
- Total \$385.44

4. 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

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 Everest National Insurance Co must remit to Peak Integrated Health \$385.44 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		May 12, 2023
Signature	Medical Fee Dispute Resolution Officer	<small>Date</small>

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 electrónico CompConnection@tdi.texas.gov.