Division of Workers' Compensation

PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Brandon Coby Marrow

MFDR Tracking Number
M4-23-1479-01

DWC Date Received
February 22, 2023

Respondent Name
Texas Association of Counties

Carrier's Austin Representative
Box Number 47

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 26, 2023	97750	$160.49	$160.49
	Total	$160.49	$160.49

Requestor's Position

"…We feel that the payment was less than what is owed to us. …This is a 3 hour evaluation that covers many different functionalities to ensure the patient is ready to safely go back to work after completing the Work Hardening program."

Amount in Dispute: $160.49

Respondent's Position

"As reflected in the EOBs, the County properly reimbursed Mr. Marrow for the FCE in accordance with the Texas Workers' Compensation Act and Division Rules."

Response submitted by: Burns Anderson Jury & Brenner, LLP

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 §134.204 sets out the guidelines for FCE billing and reimbursement.
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:

- 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules
- 600 – Allowance based on maximum number of units allowed according to the fee schedule and/or service code description or regulations
- 877 – Reimbursement is based on contracted rate
- 118 – Benefit maximum for this time period or occurrence has been reached
- 45 – Charge exceeds fee schedule/maximum/allowable or contracted/legislated fee arrangement
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 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 January 2023. Specifically, 97750 – FC. The carrier reduced the allowed

amount based on benefit maximum reached, contracted rate reached and workers' compensation fee schedule. Review of the submitted documentation found insufficient evidence to support a contract exists between the requestor and respondent. The benefit maximum is based on DWC Rule 134.204 discussed below. The disputed service will be reviewed per applicable fee guidelines.

2. DWC Rule 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; The insurance carrier's denial for maximum benefit is not supported as review of the medical bill found twelve units or three hours.

DWC Rule §134.203 establishes the maximum allowable reimbursement as (DWC Conversion Factor ÷ Medicare Conversion Factor) x Medicare Payment = MAR

DWC Rule 28 TAC §134.203 (b) (1) 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.

Code	Practice Expense	Allowed Amount	Medicare Policy
97750	0.55	32.4/23.77	First unit paid at full rate, 2nd through 12th unit at reduced rate

The *MPPR Rate File* that contains the payments for 2023 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 Tyler, Texas.
- The carrier code for Texas is 4412 and the locality code for Tyler is 99.

The maximum allowable reimbursement based on carrier and location is found below.

- Code 97750 first unit allowable 32.4 x 62.46/34.6062 = $63.54
- Code 97750 15 units allowable (MPPR reduction applies) 23.77 x 62.46/34.6062 x 15 = $512.74
- Total MAR $576.28

3. The total allowable DWC fee guideline reimbursement is $576.28 the insurance carrier paid $370.27. The requestor is seeking $160.49. 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.

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 Texas Association of Counties must remit to Brandon Coby Marrow $160.49 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

______________________	______________________	April 4, 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.