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

General Information

Requestor Name
Sabrena C Simmons

Respondent Name
LM Insurance Corp

MFDR Tracking Number
M4-23-1634-01

Carrier's Austin Representative
Box Number 1

DWC Date Received
March 10, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 19, 2022	97750	$181.65	$0.00
	Total	$181.65	$0.00

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/ [sic] conversation factors for the date of service billed are utilized for this claim. We have established the appropriate MAR by utilizing the CMS Centers for Medicare and Medicaid Services as per the above and as per the attached formula and printouts from the CMS website."

Amount in Dispute: $181.65

Respondent's Position

"We have again reviewed payment for the services of July 19, 2022 and determined that reimbursement was issued according to the guidelines provided by the Texas Medical Fee Schedule. The provider billed 97750 with 12 units. The first unit for 97750 was paid at $63.55 and each additional unit was reimbursed with the multiple payment reduction applies in the amount of $46.84 per unit. Total payment issued $578.79 is appropriate.

No additional payment is due."

Response submitted by: Liberty Mutual

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
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 876 – Fee schedule amount is equal to the charge.

Issues

1. What is the rule applicable to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for Code 97750 performed in July 2022. The carrier reduced the allowed amount based on multiple procedure rules.

   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.

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	0.52	35.21/25.95	First unit paid at full rate, 2nd through 12th unit at reduced rate

The *MPPR Rate File* that contains the payments for 2022 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.

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

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

- Code 97750 first unit allowable 35.21 x 62.46/34.6062 = $63.55
- Code 97750 15 units allowable (MPPR reduction applies) 25.95 x 62.46/34.6062 x 15 = $515.20
- Total MAR $578.75

2. The total allowable DWC fee guideline reimbursement is $578.75 the insurance carrier paid $578.79. No additional payment 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 not 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 $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		April 7, 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.