



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Sabrena C Simmons

**Respondent Name**

Indemnity Insurance Co of North America

**MFDR Tracking Number**

M4-23-1723-01

**Carrier's Austin Representative**

Box Number 15

**DWC Date Received**

March 16, 2023

### Summary of Findings

| Dates of Service  | Disputed Services | Amount in Dispute | Amount Due |
|-------------------|-------------------|-------------------|------------|
| November 14, 2022 | 97750             | \$181.65          | \$0.00     |
| <b>Total</b>      |                   | \$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/conversation(sic) factors for the date of service billed are utilized for this claim. We have calculated the appropriate MAR by utilizing the CMS Centers for Medicare and Medicaid Services as per the above and per the attached formula and print outs from the CMS website."

**Amount in Dispute:** \$181.65

### Respondent's Position

"We have again reviewed payment for the services of November 14, 2022, and determined that reimbursement was issued according to the guidelines provided by the Texas Medical Fee Schedule."

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 reimbursement guidelines for FCEs.
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
- 876 – Fee schedule amount is equal to the charge
- 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 November 2022. The carrier reduced the allowed amount based on the workers compensation fee schedule and multiple procedure payment rules.

DWC Rule 28 TAC 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

DWC Rule 28 TAC §134.203 (c) (1) states in pertinent part, to determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is yearly conversion factor of disputed services.

The applicable Medicare payment policy for physical therapy is Multiple Procedure Payment Reduction (MPPR). The insurance carrier's reduction is supported.

2. 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 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.

The following formula represents the calculation of the DWC MAR at DWC Rule 28 TAC §134.203 (c)(1) & (2).

- $(\text{DWC Conversion Factor} \div \text{Medicare Conversion Factor}) \times \text{Medicare Payment} = \text{MAR}$
- First unit  $62.46/34.6062 \times \$25.21 = \$63.55$
- Second through twelfth  $62.46/34.6062 \times 25.95 \times 11 = \$578.75$
- Total MAR = \$578.75

3. 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. The amount ordered is \$0.00.

**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**

\_\_\_\_\_  
Signature

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

\_\_\_\_\_  
Date

April 13, 2023

***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.**

- 1.