TDI 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
Peak Integrated Healthcare

Respondent Name
Arch Indemnity Insurance Co

MFDR Tracking Number
M4-23-2320-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
May 17, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 17, 2023	97110-GP	$346.86	$174.72
February 17, 2023	97112-GP	$132.76	$270.98
March 27, 2023	99213	$174.71	$97.38
March 27, 2023	99080-73	$15.00	$15.00
	Total	$669.33	$558.08

Requestor's Position

The requestor did not submit a position statement with this request for medical fee dispute. They did submit a copy of their reconsideration that states, "These bills were denied for "Extent of Injury", and this is incorrect. The units are for 6 units of 97110 and 2 units for 97112. Also, Office visits are recommended to be medically necessary."

Amount in Dispute: $669.33

Respondent's Position

The Austin carrier representative for Arch Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on May 23, 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 TAC §124.2 sets out insurance carrier reporting and notification requirements.
3. 28 TAC §129.5 sets out the reimbursement guidelines for work status reports.
4. 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:

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 219 - Based on extent of injury.

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 reimbursement of professional medical services rendered in February and March of 2023. The respondent denied the charges based on extent of injury.

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 disputed charges for February 17, 2023 are.
    - 97110-GP, Therapeutic procedure, 1 or more areas, each 15 minutes, range of motion and flexibility, six units.
    - 97112-GP, Therapeutic procedure, 1 or more areas, each 15 minutes, neuromuscular reeducation, two units.

    The disputed charges for March 27, 2023 are.
    - 99213- Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
    - 99080-73, Work Status Report.

The applicable DWC fee guideline for physical therapy and physician services is DWC Rule 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 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 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

- 99213 – 64.83/33.8872 x $91.33 = $174.72
- 97110 1st unit – 65.83/33.8872 x $29.49 = $56.42
- 97110 2nd – 6th unit – 64.83/33.8872 x $22.43 = $214.56
- 97112 – 64.82/33.8872 x $25.45 x 2 units = $97.38
- 99080 – 73, Allowed amount $15 per DWC Rule 28 TAC §129.5(j).

3. The total allowable DWC fee guideline reimbursement is $558.08. 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 $558.08.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $558.08 additional reimbursement for the services in dispute. It is ordered that Arch Indemnity Insurance Co must remit to Peak Integrated Healthcare $558.08 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 30, 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.