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
Zurich American Insurance Co

MFDR Tracking Number
M4-23-2330-01

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
March 16, 2023	97110-GP	$258.90	$166.78
March 16, 2023	97112-GP	$16.46	$0.00
	Total	$275.36	$166.78

Requestor's Position

The requestor did not submit a position statement with their request for medical fee dispute. They did submit a copy of their reconsideration that states, "After reconsideration we were only partially reimbursed. We argue that we should be paid according to MPPR rules."

Amount in Dispute: $275.36

Respondent's Position

The Austin carrier representative for Zurich American 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 (TAC) §133.307 sets out the guidelines for the resolution of medical fee disputes.

2. 28 TAC §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:

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 01 – The charge for the procedure exceeds the amount indicated in the fee schedule.
- MZ – The usual treatment session provided in the home or office setting is 30 to 45 minutes. The medical necessity of services for an unusual length of time must be documented.
- W3 – The benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.

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 physical therapy services rendered in March of 2023. The carrier reduced the allowed amount based on workers compensation fee schedule. 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 applicable Medicare payment policy is found at www.cms.gov, Medicare Claims Processing Manual, Chapter 5, Section 10.7 Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services. *Medicare applies a multiple procedure payment reduction (MPPR) to the practice expense (PE) payment of select therapy services. The reduction applies to the HCPCS codes contained on the list of "always therapy" services (see section 20), excluding A/B MAC (B)-priced, bundled and add-on codes, regardless of the type of provider or supplier that furnishes the services.*

Medicare applies an MPPR to the PE payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures.

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.
- Code 97112 has a PE of .50 and will receive full reimbursement ($33.86) for the first unit and reduced payment ($25.45) on the second unit.
- Code 97110 has a PE of .42 and will receive reduced payment of $22.43 per unit.

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

- 97112 – 64.83/33.8872 x $33.86 = $64.78
- 97112 – 64.83/33.8872 x 25.45 = $48.69
- 97110 – 64.83/33.8872 x $22.43 x 6 = $257.47
- Total MAR = $370.94

2. The total allowed DWC fee guideline reimbursement is $370.94. The insurance carrier paid $204.26. An additional payment of $166.78 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 $166.78.

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 Zurich American Insurance Co must remit to Peak Integrated Healthcare $166.78 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		July 12, 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 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 three, 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 tres o correo electronico CompConnection@tdi.texas.gov.