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
LM INSURANCE CORP

MFDR Tracking Number
M4-23-2418-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
May 24, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 30, 2023	Code 97110-GP	$81.36	$0.00
January 30, 2023	Code 97112-GP	$16.13	$0.00
	Total	$97.49	$0.00

Requestor's Position

"EOB received; denial of payment noted. I am resubmitting the claim for payment for the following reasons: THIS IS NOT A DUPLICATE CLAIM/SERVICE. This is an incorrect partial payment. ON this date of service, the patient completed physical therapy at our facility. Carrier is not paying accordingly to MULTIPLE PROCEDURE PAYEMNT REDUCTION FOR SELECTED THERAPY SERVICES."

Amount in Dispute: $97.49

Respondent's Position

"We have gain reviewed payment for the services of January 30, 2023, by Peak Integrated Healthcare and determined that reimbursement was issued according to guidelines provide by the Texas Medical Fee Schedule. No additional payment is due."

Response submitted by: Liberty Mutual Insurance

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 procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.

Denial Reasons

- 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
- 119 – no denial reason given
- P12 – no denial reason given
- 193 – Original payment decision is being maintained. Upon review, it was determine that this claim was processed

Issues

1. What are the applicable rules for the services in dispute?

2. Is the Requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement in the amount of $97.49 for CPT Code 97110-GP and 97112-GP for dates of service January 30, 2023.

   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 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.

Review of the submitted medical bills provided indicates that code 97110-GP was billed with six units and code 97112-GP with 2 units date of service in dispute. Per the MPPR policy the first unit will be reimbursed at the full payment and subsequent units will have the PE payment factor 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 Fort Worth, TX.
- The carrier code for Texas is 4412 and the locality code for Fort Worth is 28.
- The first unit for Code 97112 has a full payment with the highest practice expense rate of 0.50 with reimbursement of $34.28 and any subsequent units with a reduced payment in the amount of $25.85
- Code 97110 has a practice expense payment factor of 0.42 which is not the highest; reduced reimbursement in the amount of $22.78
- The DWC Conversion Factor is 64.83
- The Medicare Conversion Factor is 33.8872

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

Applicable 28 TAC 134.203(h) states that the total reimbursement is the lesser of the maximum allowable reimbursement (MAR) and the billed amount.

Date of Service	Code	Units	Medicare Payment	Maximum allowable Reimbursement	Billed Amount	Lesser of MAR and billed amount
January 30, 2023	97112 -GP	1	$34.28	$65.58	$131.16	$65.58
January 30, 2023	97112 -GP	1	$25.85	$49.45		$49.45
January 30, 2023	97110 -GP	6	$22.78	$261.48	$342.84	$261.48
					Total	$376.51

2. The total allowable DWC fee guideline reimbursement is $376.51. The insurance carrier paid $376.51. Reimbursement in the amount of $0.00 is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that no additional reimbursement of $0.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

[redacted]

Signature	Medical Fee Dispute Resolution Officer	June 23, 2023 Date

Your Right to Appeal

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 3 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 3 o correo electronico CompConnection@tdi.texas.gov.