



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Peak Integrated Healthcare

**Respondent Name**

Everest National Insurance Co

**MFDR Tracking Number**

M4-24-0258-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

October 4, 2023

### Summary of Findings

| Dates of Service  | Disputed Services | Amount in Dispute | Amount Due       |
|-------------------|-------------------|-------------------|------------------|
| July 31, 2023     | 97110-GP          | \$346.86          | \$263.89         |
| July 31, 2023     | 97112-GP          | \$132.76          | \$116.29         |
| August 14, 2023   | 97110-GP          | \$346.86          | \$263.89         |
| August 14, 2023   | 97112-GP          | \$132.76          | \$116.29         |
| August 22, 2023   | 97110-GP          | \$346.86          | \$263.89         |
| August 22, 2023   | 97112-GP          | \$132.76          | \$116.29         |
| September 1, 2023 | 99213             | \$174.71          | \$174.71         |
| September 1, 2023 | 99080-73          | \$15.00           | \$15.00          |
| <b>Total</b>      |                   | <b>\$1628.57</b>  | <b>\$1330.25</b> |

### Requestor's Position

The requestor did not submit a position statement with their request for MFDR. They did submit a copy of their reconsideration from October 4, 2023 with the statement, "We do not agree that these claims were processed properly. These bills should be paid for AUTHORIZED therapy that was APPROVED. Also the office visit is for a compensable injury. Please process for payment."

**Amount in Dispute:** \$1,628.57

### Respondent's Position

“Our bill audit company has determined no further payment is due. The rationale for this determination is found below. ...The compensable injury does not extend to include lumbar intervertebral disc disorder with radiculopathy, MMI reached 7/23/22, the IR is 0%.”

**Response submitted by:** Gallagher Bassett

## **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 §124.2](#) sets out the insurance carrier notification requirements.
3. [28 TAC §129.5](#) sets out the payment guidelines for work status reports.
4. [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:

- 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
- 219 – Based on extent of injury
- ZK10 – Resolution Manager Denial
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

## Issues

1. Did the respondent support the extent of injury denial?
2. What is the rule applicable to reimbursement of physical therapy services?
3. What rule is applicable to office visits/reports?
4. Is the requestor entitled to additional reimbursement?

## Findings

1. The requestor is seeking reimbursement for professional medical services rendered on July 31, 2023, August 14, 2023, August 22, 2023 and September 1, 2023. The insurance carrier denied the services as claim not covered by payor and 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 regarding insurance carrier notifications states in the following sections:

(c) The insurance carrier must notify the division and the claimant of its denial of a claim based on non-compensability or lack of coverage in accordance with this section and as otherwise provided by this title.

(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.

(j) Notification to the division as required by subsections (b) - (e) of this section requires the insurance carrier to use electronic filing, as that term is used in §102.5(e) of this title (concerning General Rules for Written Communications to and from the Division) with the division, according to the requirements in Subchapter B of this title (concerning Insurance Carrier Claim Electronic Data Interchange Reporting to the Division).

(1) In addition to the electronic filing requirements of this subsection, when an insurance carrier notifies the division of a denial, Notice of Continuing Investigation, or dispute of disability as required by this section, it must provide the division a written copy of the notice provided to the claimant as described under subsections (g) - (i) and (k) of this section, as applicable.

(2) The notification requirements of this section are not considered completed until the copy of the notice provided to the claimant is received by the division.

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. Review of the submitted documentation found the requestor received prior authorization from MEDINSIGHTS on July 18, 2023 for three visits of Code 97110 (6) and 97112 (2) that was valid from July 18, 2023 to October 16, 2023.

DWC Rule 28 TAC §134.203 (c)(1) states, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) 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 \$52.83..."

Medicare Claims Processing Manual Chapter 5, 10.3.7-effective June 6, 2016, titled Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services, states:

Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures with dates of service prior to April 1, 2013, furnished to the same patient on the same day, full payment is made for work and malpractice and 80 percent payment is made for the PE for services submitted on professional claims (any claim submitted using the ASC X12 837 professional claim format or the CMS-1500 paper claim form) and 75 percent payment is made for the PE for services submitted on institutional claims (ASC X12 837 institutional claim format or Form CMS-1450).

For subsequent units and procedures with dates of service on or after April 1, 2013, furnished to the same patient on the same day, full payment is made for work and malpractice and 50 percent payment is made for the PE for services submitted on either professional or institutional claims.

To determine which services will receive the MPPR, contractors shall rank services according to the applicable PE relative value units (RVU) and price the service with the highest PE RVU at 100% and apply the appropriate MPPR to the remaining services. When the highest PE RVU applies to more than one of the identified services, contractors shall additionally sort and rank these services according to highest total fee schedule amount, and price the service with the highest total fee schedule amount at 100% and apply the appropriate MPPR to the remaining services.

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.

(DWC Conversion Factor ÷ Medicare Conversion Factor) x Medicare Payment = MAR

- July 31, 2023 – 97110-GP (6 units)  $64.83/33.8872 \times 22.99 \times 6 = \$263.89$   
97112-GP (1<sup>st</sup> unit)  $64.83/33.8872 \times 34.70 = \$66.38$   
97112 – (2<sup>nd</sup> unit)  $64.83/33.8872 \times \$26.09 = \$49.91$
- August 14, 2023 - 97110-GP (6 units)  $64.83/33.8872 \times 22.99 \times 6 = \$263.89$   
97112-GP (1<sup>st</sup> unit)  $64.83/33.8872 \times 34.70 = \$66.38$   
97112 – (2<sup>nd</sup> unit)  $64.83/33.8872 \times \$26.09 = \$49.91$
- August 22, 2023 - 97110-GP (6 units)  $64.83/33.8872 \times 22.99 \times 6 = \$263.89$   
97112-GP (1<sup>st</sup> unit)  $64.83/33.8872 \times 34.70 = \$66.38$   
97112 – (2<sup>nd</sup> unit)  $64.83/33.8872 \times \$26.09 = \$49.91$
- The total allowable for the physical therapy is \$1,140.54

3. The office visit for date of service September 1, 2023 was also denied for not covered by payor/contractor and extent of injury. As stated above the extent of injury denial will not be considered, the not covered by payor is not supported.

The fee schedule guidelines are the same as above. The MAR calculation for Code 99213 is  $64.83/33.8872 \times \$91.33 = \$174.72$ . The requestor seeks \$174.71. This amount is recommended.

Code 99080-73. DWC Rule §129.5(j) states in pertinent part, the amount of reimbursement shall be \$15.00. This amount is recommended.

4. The total allowable DWC fee guideline reimbursement is  $\$1140.54 + \$174.71 + 15 = \$1,330.25$ . 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.

**ORDER**

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to additional reimbursement for the services in dispute. It is ordered that Everest National Insurance Co must remit to Peak Integrated Healthcare \$1,330.25 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

**Authorized Signature**

\_\_\_\_\_  
Signature

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

\_\_\_\_\_  
Date

November 9, 2023

**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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).