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
Service Lloyds Insurance Co

MFDR Tracking Number
M4-25-0448-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
October 25, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 13, 2024	97750-GP	$557.52	$423.62
	Total	$557.52	$423.62

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a document titled "Request for Reconsideration" dated August 21, 2024 and October 25, 2024 that states, "After reconsideration we still have received no reason for denial or payment for this date of service. We performed this evaluation of patient and it should be paid."

Amount in Dispute: $557.52

Respondent's Position

"We have reprocessed DOS 06/13/2024 as requested under Bill ID SLTX-279608, DOS 06/13/2024, Charged amount $557.52. SLTX-279608 has been reviewed and Service Insurance is standing on the previous denial as the (redacted) is disputed on the workers compensation claim reported."

Response submitted by: Mitchell

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 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the reimbursement guidelines for physical performance tests.
3. 28 TAC §134.204 sets out the reimbursement guidelines for case management reports.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 351 – No additional reimbursement allowed after review or appeal/reconsideration.
- 375 – Please see special *Note* below.
- A1 – Claim/service denied.
- P12 – Workers' Compensation Jurisdictional fee schedule adjustment.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- XA1 – Claim/service denied.
- Left (redacted) has been disputed

Issues

1. Did the respondent support requirements of Plain Language Notification?
2. What rule(s) is applicable to reimbursement?

Findings

1. 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 requestor is seeking reimbursement for physical performance test (code 97750-GP) x eight units rendered on June 13, 2024. The applicable fee guideline calculation is shown below.

   DWC Rule §134.203 is the applicable rule related to Code 97750 – (Physical performance test or TAC Rule §134.203 (b) (1) states in pertinent parts for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

   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 medical bill indicates eight units were submitted for Code 97750. The first unit is paid 100% of the Physician Fee Schedule for Garland, Texas in the amount of $34.21. The other seven units will be paid at the reduced amount of $24.82.

   The MAR is calculated per TAC Rule §134.203 (c)(1) which states in pertinent part, for service categories of Evaluation & Management, General Medicine, Physical Medicine when performed in an office setting, the conversion factor for the date of service in dispute is used

or DWC Conversion Factor/Medicare Conversion Factor multiplied by physician fee schedule allowable or

- 67.81/33.2875 x $34.21 = $69.69
- 67.81/33.2875 x 24.82 x 7 = $353.93
- Total allowable = $423.62

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 reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that Service Lloyds Insurance Co must remit to Peak Integrated Healthcare $423.62 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		November 18, 2024
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 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.