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
Twin City Fire Insurance Co

MFDR Tracking Number
M4-25-1009-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
January 10, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 16, 2024	99213	$185.89	$185.89
September 16, 2024	99080-73	$15.00	$15.00
October 11, 2024	97110-GP	$314.88	$228.98
October 11, 2024	97112-GP	$17.09	$.02
October 15, 2024	97110-GP	$314.88	$228.98
October 15, 2024	97112-GP	$17.09	$.02
	Total	$922.21	$658.89

Requestor's Position

The requestor did not submit a position statement for the services in dispute. They did submit a document titled "Request for Reconsideration" dated 11/19/2024 AND 01/10/2025 that states in relevant parts, "**FOR 10/11,10/15/2024 DATES OF SERVICE**. These bills were denied FULL PAYMENT …We requested authorization for CPT codes 97110 AND 97112 before scheduling treatment. **The units are for 6 units of 97110 and 2 units for 97112. FOR 09/16/2024 DATE OF SERVICE.** The original bills were sent well before the time limit of 95 days for filing as demonstrated on the 2 forms of proof attached."

Amount in Dispute: $922.21

Respondent's Position

The Austin carrier representative for Twin City Fire Insurance Co is Burns Anderson Jury & Brenner LP. The representative was notified of this medical fee dispute on January 14, 2025

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 §134.600 sets out the requirements of prior authorization.

3. 28 TAC §134.203 sets out the reimbursement guidelines for professional medical services.
4. 28 TAC §129.5 sets out reimbursement of work status reports.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 01 – The charge for the procedure exceeds the amount indicated in the fee schedule.

- APRV - The Provider's charges were reviewed with consideration of the Payors UR/Pre-Authorization Decision(s) governing this Claimant. The listed allowance reflects the results(s) of their Decision(s) and all applicable Bill Review Decision(s).

- 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.

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- WOCP – WorkCompEDI Scanning/Data Capture of Professional bill.
- 151 – Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
- 60 – The provider has billed for the exact services on a previous bill.
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
- EXPA – Service exceeds Pre-Authorized approval. Please provide documentation and/or additional authorization for the service not included in the original documentation.
- UY – The number of units billed for this procedure code exceeds the reasonable number usually provided in a given setting, as defined within the Medically Unlikely Edits (MUEs) which is published and maintained by the Centers for Medicare and Medicaid Services. The Provider's charge was granted an allowance up to the MUE value.
- ZR – The provider or a different provider has billed for the exact service on a previous bill where no allowance was originally recommended.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the rule applicable to reimbursement of physician services and work status reports?
3. What are the reimbursement guidelines for physical therapy?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking payment of a physician's visit and work status report for date of service September 16, 2024. The information submitted with the request for MFDR indicates the claim denied as a duplicate and workers compensation fee schedule. Also in dispute are physical therapy services rendered on October 11th and 15th, 2024. The insurance carrier reduced the payment based on pre-authorization exceeded and units exceed the usual treatment session.

The respondent (Twin City Fire Insurance Co) did not submit a position statement in response to this request for MFDR. The information available to DWC does not support the denial reasons presented on the EOB for the physician services as no supporting documentation was presented by the respondent. These services will be reviewed per applicable fee guidelines.

Review of the "Medata" document indicates certification was recommended for six sessions of physical therapy from September 24, 2024, to March 24, 2025. This certification did not limit the number of units rendered during the session or the time of each session. The insurance carrier's reduction of units is not supported.

2. Review of the information known to the Division found that the treating physician is Dr. Shaun Marek who is listed as the provider treating the injured worker on September 16, 2024, as such the physician should be reimbursed per the applicable fee guideline. The DWC fee guideline for professional medical services is found in DWC Rule 28 TAC §134.203 (c) "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. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

   - The location of the professional service is Dallas, Texas
   - The CMS physician fee schedule allowable for the date of service at this location is $91.25. The DWC Conversion Factor is $67.81. The Medicare Conversion Factor is 33.2875. The MAR calculation is 67.81/33.2875 x $91.25 = $185.89

The requestor is also seeking payment of 99080-73, Work Status Report. The insurance carrier denied for allowance exceeded. DWC Rule §129.5 (e)(j)states in pertinent parts, "The doctor, delegated physician assistant, or delegated advanced practice registered nurse shall file the Work Status Report:

(1) after the initial examination of the injured employee, regardless of the injured employee's work status;

(2) when the injured employee experiences a change in work status or a substantial change in activity restrictions;
The amount of reimbursement shall be $15. A doctor, delegated physician assistant, or delegated advanced practice registered nurse shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section.

Review of the submitted DWC073 indicates a change in work status. The insurance carrier's denial is not supported. The amount of $15 is due to the requestor.

3. The applicable DWC fee guideline for physical therapy is DWC Rule 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 procedure.*

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.

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 2024 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 Dallas, Texas.
- The carrier code for Texas is 4412 and the locality code for Dallas is 11.
- MAR calculation = DWC Conversion Factor ÷ Medicare Conversion Factor) x Medicare Payment
- The MPPR rate for code 97110 (6 units). The MPPR rate is not the highest, all units paid at MPPR reduction $22.48
    - 67.81/33.2875 x $22.48 x 6 = $274.76

- The MPPR rate for code 97112 (2 units). The MPPR rate is the highest, 1st unit full allowable $33.88, 2nd unit MPPR reduction $25.50
    - 67.81/33.2875 x $33.88 = $69.02
    - 67.81/33.2875 x 25.50 = $51.95
    - Total MAR = $120.97

- The total allowable for dates of service October 11, 2024 and October 15, 2024 is $395.73 x 2 = $791.46. The insurance carrier paid $333.46. An additional $458.00 is due to the requestor.

4. The total additional payment due to the requestor is $658.89. This amount 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 requestor has established that additional reimbursement is due.

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 Twin City Fire Insurance Co must remit to Peak Integrated Healthcare $658.89 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		April 9, 2025
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.