TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS HEALTH FORT WORTH

Respondent Name
KELLER INDEPENDENT SCHOOL DISTRICT

MFDR Tracking Number
M4-19-1754-01

Carrier's Austin Representative
Box Number 43

MFDR Date Received
November 27, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Physical therapy services have not been reimbursed per state fee schedule rules."

Amount in Dispute: $30.15

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill was paid according PER SECTION 3134 OF THE AFFORDABLE CARE ACT; MULTIPLE PROCEDURE PAYMENT REDUCTION FOR SELECTED THERAPY SERVICES HAVE BEEN APPLIED TO THIS BILL … The reduction applies to … codes contained on the list of 'always therapy' services that are paid under the physician free schedule, regardless of the type of provider or supplier that furnishes the services …"

Response Submitted by: CareWorks Managed Care Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
June 19, 2018 to June 25, 2018	Outpatient Physical Therapy	$30.15	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the hospital facility fee guideline for outpatient services.
3. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 59 – PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - W3 – REPORTING PURPOSES ONLY.

Issues

Is the requestor entitled to additional reimbursement?

Findings

This dispute regards physical therapy services performed in an outpatient facility. Such services are not paid under Medicare's Outpatient Prospective Payment System (OPPS) but using Medicare's Physician Fee Schedule. Per DWC's *Hospital Facility Fee Guideline*, Rule §134.403(h), if Medicare reimburses using other fee schedules, services are paid using DWC guidelines applicable to the code on the date provided. DWC *Medical Fee Guideline for Professional Services*, Rule §134.203(c), requires the maximum allowable reimbursement (MAR) be determined by applying Medicare payment policies modified by DWC rules. The MAR is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the 2018 DWC conversion factor of $58.31.

When more than one unit is billed of therapy services designated by multiple-procedure payment indicator '5', Medicare policy requires the first unit of therapy with the highest practice expense for that day be paid in full. Payment is reduced by 50% of the practice expense (PE) for each extra therapy unit provided on that date.

Reimbursement is calculated as follows:

- Procedure code 97140 has a Work RVU of 0.43 multiplied by the Work GPCI of 1.007 is 0.43301. The practice expense RVU of 0.35 multiplied by the PE GPCI of 0.986 is 0.3451. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.747 is 0.00747. The sum is 0.78558 multiplied by the DWC conversion factor of $58.31 for a MAR of $45.81. For each extra therapy unit after the first unit of the code with the highest PE, payment is reduced by 50% of the practice expense. The PE for this code is not the highest for any of the dates billed. The PE reduced rate is $35.75. This amount multiplied by 1 unit each for 3 visits totals $107.25

The total MAR (maximum allowable reimbursement) for the services in dispute is $107.25.
The insurance carrier paid $107.25. No additional payment is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	December 20, 2018
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 Rule §133.307.

A party seeking review must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M) in accordance with the form's instructions. The division must receive the request within twenty days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the division, using the contact information listed on the form, or to the field office handling the claim.

The party seeking review must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Include a copy of this *Medical Fee Dispute Resolution Findings and Decision*** together with any other information required by 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.