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
TX HEALTH FLOWER MOUND

Respondent Name
NORTHWEST INDEPENDENT SCHOOL DISTRICT

MFDR Tracking Number
M4-19-3711-01

Carrier's Austin Representative
Box Number 43

MFDR Date Received
April 5, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Underpaid/Denied Physical Therapy Rate – Phys Conversion Factor applied to Hospital Service.... Physician conversion factors are NOT APPLICABLE."

Amount in Dispute: $141.68

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: York

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 5, 2018 to November 28, 2018	Outpatient Physical Therapy	$141.68	$7.35

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 109 - Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
   - 246 – THIS NON-PAYABLE CODE IS FOR REQUIRED REPORTING ONLY.
   - 59 – PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES.

Issues

Is the requestor entitled to additional reimbursement?

Findings

This dispute regards outpatient physical therapy services not paid under Medicare's Outpatient Prospective Payment System but using Medicare's Physician Fee Schedule. DWC *Hospital Fee Guideline* Rule §134.403(h) requires use of the fee guideline applicable to the code on the date provided if Medicare reimburses using other fee schedules. *Professional Fee Guideline* 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 a DWC conversion factor.

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 97110 (November 5, November 8, November 12, November 15, November 19, November 26, and November 28, 2018) has a Work RVU of 0.45 multiplied by the Work GPCI of 1 is 0.45. The practice expense RVU of 0.4 multiplied by the PE GPCI of 0.938 is 0.3752. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.796 is 0.01592. The sum is 0.84112 multiplied by the DWC conversion factor of $58.31 for a MAR of $49.05. 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 billed for this date. The PE reduced rate is $38.11 at 3 units is $114.33, for 7 visits totals $800.31.
- Procedure code 97140 (November 5, November 8, November 12, November 15, November 19, November 26, and November 28, 2018) has a Work RVU of 0.43 multiplied by the Work GPCI of 1 is 0.43. The practice expense RVU of 0.35 multiplied by the PE GPCI of 0.938 is 0.3283. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.796 is 0.00796. The sum is 0.76626 multiplied by the DWC conversion factor of $58.31 for a MAR of $44.68. 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 billed for this date. The PE reduced rate is $35.11, for 7 visits totals $245.77.

The reimbursement for the disputed services is $1,046.08. The carrier paid $1,038.73. The amount due is $7.35.

Conclusion

The division finds the requestor has established additional payment is due. The amount ordered is $7.35.

ORDER

Pursuant to Texas Labor Code §413.031 and §413.019 (if applicable), the division determines the requestor is entitled to additional reimbursement. The division hereby ORDERS the respondent to remit to the requestor $7.35, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

______________________	Grayson Richardson	April 24, 2019
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.