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 OF PLANO

Respondent Name
GREAT DIVIDE INSURANCE COMPANY

MFDR Tracking Number
M4-19-3813-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
April 16, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Underpaid/Denied Physical Therapy Rate."

Amount in Dispute: $19.38

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see enclosed copies of Medical Fee Dispute Resolution Request, Re-Eval EOR, and TX FS State Review on PT services."

Response Submitted by: Berkley Entertainment

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
December 4, 2018 to December 7, 2018	Outpatient Physical Therapy	$19.38	$0.00

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:
   - 246 – THIS NON-PAYABLE CODE IS FOR REQUIRED REPORTING ONLY.
   - 350 – BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 356 – THIS OUTPATIENT ALLOWANCE WAS BASED ON THE MEDICARE'S METHODOLOGY (PART B) PLUS THE TEXAS MARKUP.
   - 652 – THIS PROCEDURE CODE IS USED FOR REPORTING PURPOSES ONLY. NO PAYMENT IS DUE.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

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. DWC *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 (December 4, December 5, December 6, and December 7, 2018) has a Work RVU of 0.45 multiplied by the Work GPCI of 1.012 is 0.4554. The practice expense (PE) RVU of 0.4 multiplied by the PE GPCI of 1.014 is 0.4056. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.768 is 0.01536. The sum is 0.87636 multiplied by the DWC conversion factor of $58.31 for a MAR of $51.10. The PE for this code is not the highest for these dates. Payment is reduced by 50% of the practice expense for each extra therapy unit after the first unit of the code with the highest PE. The PE reduced rate is $39.28, for 4 visits totals $157.12.
- Procedure code 97112 (December 4, December 5, December 6, and December 7, 2018) has a Work RVU of 0.5 multiplied by the Work GPCI of 1.012 is 0.506. The practice expense RVU of 0.47 multiplied by the PE GPCI of 1.014 is 0.47658. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.768 is 0.01536. The sum is 0.99794 multiplied by the DWC conversion factor of $58.31 for a MAR of $58.19. This code has the highest PE for these dates. The first unit is paid in full at $58.19, for 4 visits totals $232.76.
- Procedure code 97140 (December 4, December 5, December 6, and December 7, 2018) has a Work RVU of 0.43 multiplied by the Work GPCI of 1.012 is 0.43516. The practice expense RVU of 0.35 multiplied by the PE GPCI of 1.014 is 0.3549. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.768 is 0.00768. The sum is 0.79774 multiplied by the DWC conversion factor of $58.31 for a MAR of $46.52. The PE for this code is not the highest for these dates. Payment is reduced by 50% of the practice expense for each extra therapy unit after the first unit of the code with the highest PE. The PE reduced rate is $36.17, for 4 visits totals $144.68.
- Per Medicare policy regarding Correct Coding Initiative (CCI) edits, procedure code 97530 (December 5 and December 6, 2018) may not be reported with code 97140 billed for the same dates. Payment is included in the reimbursement for code 97140. Separate payment cannot be recommended.

The total allowable reimbursement for the disputed services is $534.56. The insurance carrier paid $726.72. The amount due is $0.00. 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	May 2, 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.