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 ALLIANCE

Respondent Name
LIBERTY INSURANCE CORP.

MFDR Tracking Number
M4-19-4145-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
May 13, 2019

Response Submitted By
Liberty Mutual Insurance

REQUESTOR'S POSITION SUMMARY

"Underpaid/Denied Physical Therapy Rate."

RESPONDENT'S POSITION SUMMARY

"The bill has been reviewed and payment is issued correctly."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
January 8, 2019 to January 17, 2019	Outpatient Physical Therapy	$20.43	$0.00

AUTHORITY

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:
   - 170 – REIMBURSEMENT IS BASED ON THE PHYSICIAN FEE SCHEDULE WHEN A PROFESSIONAL SERVICE WAS PERFORMED IN THE FACILITY SETTING.
   - 163 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE UNIT VALUE AND/OR THE MULTIPLE PROCEDURE RULES
   - B13 – PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT.
   - 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 of service if Medicare pays it 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.

Medicare's multiple-procedure payment reduction (MPPR) policy requires the first unit of the therapy code with the highest practice expense be paid in full. Payment is reduced by 50% of the practice expense for each extra unit of therapy (codes with multiple-procedure indicator 5) provided on the same date.

Reimbursement is calculated as follows:

- Procedure code 97140, January 8, 2019, 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 $59.19 for a MAR of $46.50. The PE for this code is not the highest for this date; payment is reduced by 50% of the practice expense. The PE reduced rate is $36.29.
- Procedure code 97140, January 17, 2019, 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 $59.19 for a MAR of $46.50. The PE for this code is not the highest for this date; payment is reduced by 50% of the practice expense. The PE reduced rate is $36.29 at 2 units is $72.58.

The total allowable reimbursement for the disputed services is $289.73. The insurance carrier paid $289.70. Additional reimbursement is not recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

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

ORDER

In accordance with Texas Labor Code §413.031, based on the information submitted for review, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	July 26, 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.