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
M4-19-4349-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
June 4, 2019

Response Submitted By
No response received

REQUESTOR'S POSITION SUMMARY

"Underpaid/Denied Physical Therapy Rate"

RESPONDENT'S POSITION SUMMARY

The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
February 1, 2019 to February 22, 2019	Outpatient Physical Therapy	$27.16	$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 division provided a copy of the Medical Fee Dispute Resolution request to the insurance carrier's Austin representative, receipt acknowledged June 12, 2019. Per 28 Texas Administrative Code §133.307(d)(1): "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." To date the insurance carrier has not responded. Consequently, this decision is based on the information available at the time of review.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 356 – THIS OUTPATIENT ALLOWANCE WAS BASED ON THE MEDICARE'S METHODOLOGY (PART B) PLUS THE TEXAS MARKUP.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 350 – BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Findings

The Austin carrier representative for Great Divide Insurance Company is Burns Anderson Jury & Brenner, LP, who acknowledged receipt of a copy of the MFDR request on June 12, 2019. Pursuant to Rule §133.307(d)(1), if the division does not receive a response within 14 calendar days of dispute notification, the division may base its decision on the available information. To date, no response has been received. Consequently, this decision is based on the information available at the time of review.

This dispute regards outpatient physical therapy services with payment subject to DWC *Professional Fee Guideline* Rule §134.203(c), which 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 therapy with the highest practice expense be paid in full. Payment is reduced by 50% of the practice expense for each extra therapy unit (codes with multiple-procedure indicator 5) provided on the same day.

Reimbursement is calculated as follows:

- Procedure code 97110 (February 1, February 4, February 6, February 8, February 13, February 15, and February 22, 2019) 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 $59.19 for a MAR of $49.79. The PE for this code is not the highest; payment is reduced by 50% of the practice expense. The PE reduced rate is $38.68. For 7 visits, the total is $270.76.
- Procedure code 97112 (February 1, February 4, February 6, February 8, February 13, February 15, and February 22, 2019) has a Work RVU of 0.5 multiplied by the Work GPCI of 1 is 0.5. The practice expense RVU of 0.47 multiplied by the PE GPCI of 0.938 is 0.44086. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.796 is 0.01592. The sum is 0.95678 multiplied by the DWC conversion factor of $59.19 for a MAR of $56.63. This code has the highest PE. For 7 visits, the total is $396.41.
- Procedure code 97140 (February 1, February 4, February 6, February 8, February 13, February 15, and February 22, 2019) 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 $59.19 for a MAR of $45.35. The PE for this code is not the highest; payment is reduced by 50% of the practice expense. The PE reduced rate is $35.64. For 7 visits, the total is$249.48.

The total allowable reimbursement for the disputed services is $916.65. The insurance carrier paid $1,062.39. The amount due is $0.00. No additional payment is recommended.

Conclusion

The division finds the requestor has not established that additional payment is due. 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	August 23, 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.