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
M4-19-4504-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
June 17, 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
March 21, 2019 to March 29, 2019	Outpatient Physical Therapy	$185.91	$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 26, 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." 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.
   - 650 – ALLOWANCE IS REDUCED PER THE MULTIPLE PROCEDURE PAYMENT REDUCTION FOR SELECTED THERAPY SERVICES.
   - 423 – CCI EDITS FOR THIS CODE HAVE NOT BEEN APPLIED AT PAYER'S DISCRETION.
   - 59 – PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 350 – BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 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 26, 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 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 payment in full for the first unit of therapy with the highest practice expense. 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 (March 21, March 22, March 25, March 27, and March 29, 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. The total for 5 visits is $193.40.
- Procedure code 97112 (March 22, March 25, March 27, and March 29, 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. The PE for this code is not the highest; payment is reduced by 50% of the practice expense. The PE reduced rate is $43.58. The total for 4 visits is $174.32.
- Procedure code 97140 (March 21, March 22, March 25, March 27, and March 29, 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. The total for 5 visits is $178.20.
- Procedure code 97161 (March 21, 2019) has a Work RVU of 1.2 multiplied by the Work GPCI of 1 is 1.2. The practice expense RVU of 1.15 multiplied by the PE GPCI of 0.938 is 1.0787. The malpractice RVU of 0.05 multiplied by the malpractice GPCI of 0.796 is 0.0398. The sum is 2.3185 multiplied by the DWC conversion factor of $59.19 for a MAR of $137.23. This code has the highest PE for this date. The first unit is paid at $137.23. The total for 1 visit is $137.23.
- Procedure code 97530 (March 22, March 25, March 27, and March 29, 2019) has a Work RVU of 0.44 multiplied by the Work GPCI of 1 is 0.44. The practice expense RVU of 0.67 multiplied by the PE GPCI of 0.938 is 0.62846. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.796 is 0.01592. The sum is 1.08438 multiplied by the DWC conversion factor of $59.19 for a MAR of $64.18. This code has the highest PE. The first unit is paid at $64.18. The total for 4 visits is $256.72.

The total allowable reimbursement for the disputed services is $939.87. The insurance carrier paid $939.92. The amount due is $0.00. No additional payment is 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

Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	August 30, 2019 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.