TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS HEALTH FLOWER MOUND

Respondent Name
NORTHWEST INDEPENDENT SCHOOL DISTRICT

MFDR Tracking Number
M4-19-4703-01

Carrier's Austin Representative
Box Number 43

MFDR Date Received
June 27, 2019

Response Submitted By
York

REQUESTOR'S POSITION SUMMARY

"Underpaid/Denied Physical Therapy Rate."

RESPONDENT'S POSITION SUMMARY

"When reviewing the MDR request, an additional amount was reviewed for code 97140 and 97110…. The bill was processed for an additional amount of $5.69 with $0.14 for interest… The check was issued on 7/16/2019…"

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
October 8, 2018 to October 31, 2018	Outpatient Physical Therapy	$114.40	$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:
   - 246 – THIS NON-PAYABLE CODE IS FOR REQUIRED REPORTING ONLY.
   - 59 – PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - W3 – REPORTING PURPOSES ONLY
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

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 97110 (October 29, 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. The PE for this code is not the highest; payment is reduced by 50% of the practice expense. The PE reduced rate is $38.11 at 2 units is $76.22.
- Procedure code 97110 (October 31, 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. The PE for this code is not the highest; payment is reduced by 50% of the practice expense. The PE reduced rate is $38.11 at 3 units is $114.33.
- Procedure code 97140 (October 8, October 11, October 15, October 18, October 22, October 25, October 29, and October 31, 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. The PE for this code is not the highest; payment is reduced by 50% of the practice expense. The PE reduced rate is $35.11. The total for 8 visits is $280.88
- Procedure code G0283 (October 18, October 22, and October 25, 2018) has a Work RVU of 0.18 multiplied by the Work GPCI of 1 is 0.18. The practice expense RVU of 0.23 multiplied by the PE GPCI of 0.938 is 0.21574. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.796 is 0.00796. The sum is 0.4037 multiplied by the DWC conversion factor of $58.31 for a MAR of $23.54. The PE for this code is not the highest; payment is reduced by 50% of the practice expense. The PE reduced rate is $17.25. The total for 3 visits is $51.75.

The total allowable reimbursement for the disputed services is $523.18. The insurance carrier paid $523.18. The amount remaining due is $0.00. No additional payment is recommended.

Conclusion

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.