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 SOUTHLAKE

Respondent Name
NORTHWEST INDEPENDENT SCHOOL DISTRICT

MFDR Tracking Number
M4-19-5014-01

Carrier's Austin Representative
Box Number 43

MFDR Date Received
July 29, 2019

Response Submitted By
York

REQUESTOR'S POSITION SUMMARY

"Underpaid/Denied Physical Therapy Rate"

RESPONDENT'S POSITION SUMMARY

"The bill was reviewed again and the original payment was maintained."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 4, 2019 to March 25, 2019	Outpatient Therapy Services	$76.11	$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 §134.203 sets out the fee guideline for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 59 – PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - W3 – REPORTING PURPOSES ONLY

Issues

Is the requestor entitled to additional reimbursement?

Findings

This dispute regards outpatient physical therapy services 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 (March 4, March 18, and March 25, 2019) has a Work RVU of 0.45 multiplied by the Work GPCI of 1.007 is 0.45315. The practice expense RVU of 0.4 multiplied by the PE GPCI of 0.986 is 0.3944. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.747 is 0.01494. The sum is 0.86249 multiplied by the DWC conversion factor of $59.19 for a MAR of $51.05. The PE for this code is not the highest; payment is reduced by 50% of the practice expense. The PE reduced rate is $39.38 at 2 units is $78.76. The total for 3 visits is $236.28.
- Procedure code 97112 (March 4, March 18, and March 25, 2019) has a Work RVU of 0.5 multiplied by the Work GPCI of 1.007 is 0.5035. The practice expense RVU of 0.47 multiplied by the PE GPCI of 0.986 is 0.46342. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.747 is 0.01494. The sum is 0.98186 multiplied by the DWC conversion factor of $59.19 for a MAR of $58.12. The PE for this code is not the highest; payment is reduced by 50% of the practice expense. The PE reduced rate is $44.40. The total for 3 visits is $133.20.
- Procedure code 97530 (March 4, March 18, and March 25, 2019) has a Work RVU of 0.44 multiplied by the Work GPCI of 1.007 is 0.44308. The practice expense RVU of 0.67 multiplied by the PE GPCI of 0.986 is 0.66062. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.747 is 0.01494. The sum is 1.11864 multiplied by the DWC conversion factor of $59.19 for a MAR of $66.21. This code has the highest PE for these dates. The first unit is paid at $66.21. The total for 3 visits is $198.63.

The total allowable reimbursement for the disputed services is $568.11. The insurance carrier paid $568.11. 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.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). 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 field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute 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.