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
UT HEALTH EAST TEXAS REHAB

Respondent Name
OHIO SECURITY INSURANCE COMPANY

MFDR Tracking Number
M4-19-5306-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
August 26, 2019

Response Submitted By
Liberty Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

"payment for services provided to the above reference patent does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code."

RESPONDENT'S POSITION SUMMARY

"The bill for DOS 04/05/19 has been reviewed and no additional payment is due bill was priced correctly…"

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
April 5, 2019	Physical Performance Testing	$195.49	$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 (DWC).

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:
   - 170 – REIMBURSEMENT IS BASED ON THE OUTPATIENT/INPATIENT FEE SCHEDULE.
   - B13 – PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT.
   - 163 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE UNIT VALUE AND/OR MULTIPLE PROCEDURE RULES
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

Issues

Is the requestor entitled to additional reimbursement?

Findings

This dispute regards physical performance testing provided in an outpatient hospital, with reimbursement subject to 28 Texas Administrative Code §134.203(c), which determines the maximum allowable reimbursement (MAR) 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 97750 has a Work RVU of 0.45 multiplied by the Work GPCI of 1 is 0.45. The practice expense RVU of 0.52 multiplied by the PE GPCI of 0.938 is 0.48776. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.796 is 0.01592. The sum is 0.95368 multiplied by the DWC conversion factor of $59.19 for a MAR of $56.45. For each extra unit after the first, payment is reduced by 50% of the practice expense. The first unit is paid at $56.45. The PE reduced rate is $42.01 at 6 units is $252.06. The total for 7 units is $308.51.

The total allowable reimbursement for the disputed services is $308.51. The insurance carrier paid $308.51. The amount due is $0.00. No additional payment is recommended.

Conclusion

For the reasons above, 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, DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	September13, 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 28 TAC §133.307.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). DWC must receive the request within twenty days of your receipt of this decision.

You may fax, mail or personally deliver the request to either the field office handling the claim or to DWC at the contact information on the form. You must send a copy to all other parties in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** along with any other information required by 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.