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 Plano

Respondent Name
Plano Independent School District

MFDR Tracking Number
M4-20-0199-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 23, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The purpose of this letter is to inform you that payment for services provided to the above referenced patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code."

Amount in Dispute: $234.49

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Additional reimbursement has been recommended in the amount of $90.53… We have attached… a copy of the carrier's check to the provider in the amount of $93.76."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 7 – 28, 2018	Outpatient Therapy Services	$234.49	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 reimbursement guidelines for outpatient hospital services.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical

services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 5044- Additional payment made on appeal/reconsideration
   - P12 – Workers compensation jurisdictional fee schedule
   - 119 – Benefit maximum for this time period or occurrence has been reached
   - 170 – Reimbursement is based on the outpatient/inpatient fee schedule

Issues

1. Is the carrier's reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for outpatient therapy services performed from December 7 – 28, 2018. The carrier reduced the allowed amount based on the workers compensation fee schedule

   28 TAC 134.403 applies to outpatient hospital services. Section (h) requires when Medicare reimburses using other Medicare fee schedules, reimbursement is made using the applicable Division Fee Guideline in effect for that service on the date was provided.

   The applicable DWC fee guideline for physical therapy is 28 TAC §134.203 discussed below.

2. 28 TAC 134.203 (b) (1) requires the application of Medicare payment policies applicable to professional services.

   Review of the Medicare policies finds multiple procedure payment reduction (MPPR) applies to the Practice Expense (PE) of certain time-based physical therapy codes when more than one unit or procedure is provided to the same patient on the same day.

   The MPPR policy allows for full payment for the unit or procedure with the highest Practice Expense (PE) payment factor; and for subsequent units the Practice Expense (PE) payment factor is reduced by 50 percent.

   Review of the submitted medical bill provided indicates that four procedures were billed by the health care provider. In order to determine whether the MPPR applies to the service in dispute, the DWC must rank all the services provided in December 2018 by their PE payment factor.

   Here is a chart ranking the PE payment for each of the codes billed by the health care provider.

CODE	PRACTICE EXPENSE	Medicare Policy
97110	0.4	MPPR applies on for date of service December 26, 2018
97164	**0.83**	**Highest ranked on December 26, 2018 no MPPR**
97140	0.35	MPPR applies
G0283	0.23	MPPR applies

   The *MPPR Rate File* that contains the payments for 2019 services is found at https://www.cms.gov/Medicare/Billing/TherapyServices/index.html.

   - MPPR rates are published by carrier and locality.
   - The services were provided in Plano Texas.
   - The carrier code for Texas is 4412 and the locality code for Plano is 99.

The following formula represents the calculation of the DWC MAR at §134.203 (c)(1) & (2).

(DWC Conversion Factor ÷ Medicare Conversion Factor) x Medicare Payment = MAR

Applicable 28 TAC 134.203(h) states that the total reimbursement is the lesser of the maximum allowable reimbursement (MAR) and the billed amount.

Date of Service	Code	Units	Medicare Payment	DWC Conversion Factor divided by Medicare Conversion Factor or 58.31 ÷35.9996	Billed Amount	Lesser of MAR and billed amount
December 3,2018	97110	3	$30.28 $23.53	1.62 x $30.28 x 1 = $49.05 1.62 x $23.53 x 2 = $76.23	$468.75	$125.28
December 6, 2018	97110	3	$30.28 $23.53	1.62 x $30.28 x 1 = $49.05 1.62 x $23.53 x 2 = $76.23	$468.75	$125.28
December 7, 2018	97110	2	$30.28 $23.53	1.62 x $30.28 x 1 = $49.05 1.62 x $23.53 x 1 = $38.12	$312.50	$87.17
December 10, 2018	97110	3	$30.28 $23.53	1.62 x $30.28 x 1 = $49.05 1.62 x $23.53 x 2 = $76.23	$468.75	$125.28
December 12, 2018	97110	2	$30.28 $23.53	1.62 x $30.28 x 1 = $49.05 1.62 x $23.53 x 1 = $38.12	$312.50	$87.17
December 14, 2018	97110	2	$30.28 $23.53	1.62 x $30.28 x 1 = $49.05 1.62 x $23.53 x 1 = $38.12	$312.50	$87.17
December 18, 2018	97110	2	$30.28 $23.53	1.62 x $30.28 x 1 = $49.05 1.62 x $23.53 x 1 = $38.12	$312.50	$87.17
December 19, 2018	97110	2	$30.28 $23.53	1.62 x $30.28 x 1 = $49.05 1.62 x $23.53 x 1 = $38.12	$312.50	$87.17
December 21, 2018	97110	2	$30.28 $23.53	1.62 x $30.28 x 1 = $49.05 1.62 x $23.53 x 1 = $38.12	$312.50	$87.17
December 26, 2018	97110	1	$23.53	1.62 x $23.53 x 1 = $38.12	$156.25	$38.12
December 27, 2018	97110	2	$30.28 $23.53	1.62 x $30.28 x 1 = $49.05 1.62 x $23.53 x 1 = $38.12	$312.50	$87.17
December 28, 2018	97110	2	$30.28 $23.53	1.62 x $30.28 x 1 = $49.05 1.62 x $23.53 x 1 = $38.12	$312.50	$87.17
December 7, 2018	97140	1	$21.68	1.62 x $21.68 = $35.12	$140.50	$35.12
December 12, 2018	97140	1	$21.68	1.62 x $21.68 = $35.12	$140.50	$35.12
December 14, 2018	97140	1	$21.68	1.62 x $21.68 = $35.12	$140.50	$35.12

December 18, 2018	97140	1	$21.68	1.62 x $21.68 = $35.12	$140.50	$35.12
December 19,2018	97140	1	$21.68	1.62 x $21.68 = $35.12	$140.50	$35.12
December 21,2018	97140	1	$21.68	1.62 x $21.68 = $35.12	$140.50	$35.12
December 26, 2018	97140	1	$21.68	1.62 x $21.68 = $35.12	$140.50	$35.12
December 27, 2018	97140	1	$21.68	1.62 x $21.68 = $35.12	$140.50	$35.12
December 28, 2018	97140	1	$21.68	1.62 x $21.68 = $35.12	$140.50	$35.12
December 7, 2018	G0283	1	$10.65	1.62 x $10.65 = $17.25	$118.00	$17.25
December 10, 2018	G0283	1	$10.65	1.62 x $10.65 = $17.25	$118.00	$17.25
December 12, 2018	G0283	1	$10.65	1.62 x $10.65 = $17.25	$118.00	$17.25
December 26, 2018	97164	1	$55.89	1.62 x $55.89 = $90.54	$143.75	$90.54
					Total	$1,569.69

The total allowable DWC fee guideline reimbursement is $1,569.69. The carrier paid $1,580.50. No additional payment is due.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 20, 2020 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, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

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 instructions on the form. The request must be received by DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 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.