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
DOCTORS HOSPITAL AT RENAISSANC

Respondent Name
WC SOLUTIONS

MFDR Tracking Number
M4-20-0477-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 22, 2019

Response Submitted By
RM, Review Med

REQUESTOR'S POSITION SUMMARY

"we have concluded that reimbursement received was inaccurate."

RESPONDENT'S POSITION SUMMARY

"The reduced charges were reimbursed based on the applicable TX WC Fee Schedule for the procedures, locality, and dates of service submitted on the billing form. The reduction includes the application of the CMS multiple procedures policy related to therapy services."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
July 2, 2019 to July 26, 2019	Outpatient Physical Therapy	$1,907.74	$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) in Title 28, Part 2 of the Texas Administrative Code.

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:
   - 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 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

Issues

Is the requestor entitled to additional reimbursement?

Findings

This dispute regards outpatient physical therapy services with payment subject to DWC's *Professional Fee Guideline.* Rule 28 TAC §134.203(c) determines the maximum allowable reimbursement (MAR) using 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 (Service dates: July 2, July 3, July 5, July 8, July 9, July 11, July 15, July 17, July 19, July 22, July 24, and July 26, 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 at 2 units is $77.36. The total for 12 visits is $928.32.
- Procedure code 97112 (Service dates: July 2, July 3, July 5, July 8, July 9, July 11, July 15, July 17, July 19, July 22, July 24, and July 26, 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 12 visits is $522.96.
- Procedure code 97530 (Service dates: July 2, July 3, July 5, July 8, July 9, July 11, July 15, July 17, July 19, July 22, July 24, and July 26, 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. Payment is made in full for the first unit at $64.18. The total for 12 visits is $770.16.

The total allowable reimbursement for the disputed services is $2,221.44. The insurance carrier paid $2,221.26. Additional payment is not recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of the division is to adjudicate payment following Texas laws and DWC 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 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	November 15, 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.