



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 OF PLANO

Respondent Name

PLANO INDEPENDENT SCHOOL DISTRICT

MFDR Tracking Number

M4-20-0773-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

November 25, 2019

Response Submitted By

Flahive, Odgen & Latson, Attorneys at Law, PC

REQUESTOR'S POSITION SUMMARY

"Underpaid/Denied Physical Therapy Rate"

RESPONDENT'S POSITION SUMMARY

"The provider was reimbursed pursuant to the Medical Fee Guidelines."

SUMMARY OF DISPUTE

Table with 4 columns: Dates of Service, Disputed Services, Dispute Amount, Amount Due. Row 1: January 8, 2019 to January 11, 2019, Outpatient Physical Therapy, \$29.13, \$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:
- 97 - PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- 119 - BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
- 163 - THE CHARGE FOR THIS PROCEDURE EXCEEDS THE UNIT VALUE AND/OR MULTIPLE PROCEDURE RULES
- 170 - REIMBURSEMENT IS BASED ON THE OUTPATIENT/INPATIENT FEE SCHEDULE.
- 243 - THE CHARGE FOR THIS PROCEDURE WAS NOT PAID SINCE THE VALUE OF THIS PROCEDURE IS INCLUDED/BUNDLED WITHIN THE VALUE OF ANOTHER PROCEDURE PERFORMED.
- P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- W3 - ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
- 193 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 6000 - REQUEST FOR RECONSIDERATION

Issues

Is the requestor entitled to additional reimbursement?

Findings

This dispute regards outpatient physical therapy services with payment subject to DWC *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 97140 (January 8, January 9, and January 11, 2019) 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 \$59.19 for a MAR of \$45.35. The PE for this code is not the highest for these dates; payment is reduced by 50% of the practice expense. The PE reduced rate is \$35.64. The total for 3 visits is \$106.92.

The total allowable reimbursement for the disputed services is \$106.92. The insurance carrier paid \$106.92.

No additional payment is recommended.

Conclusion

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

Authorized Signature

	Grayson Richardson	December 20, 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.