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 Flower Mound

Respondent Name
City of Plano

MFDR Tracking Number
M4-20-1038-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 23, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Underpaid/denied physical therapy rate."

Amount in Dispute: $83.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: None submitted

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 7 – 29, 2019	Outpatient physical therapy services	$83.24	$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:
    - TX59 – Processed based on multiple or concurrent procedure rules

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 January 7 – 29, 2019. The carrier reduced the allowed amount based on the multiple procedure payment rules.

   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 (b) (1) which requires the application of Medicare payment policies applicable to professional services. The insurance carrier's reduction of payment is supported.

   The Medicare 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 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. To determine the MPPR amount, the services provided are ranked by their PE payment factor shown below.

Code	Practice Expense	Allowed Amount	Medicare Policy
97110	0.4	$23.55	MPPR applies
97112	0.47	$34.48	No MPPR
97140	0.35	$21.37	MPPR applies
97530	0.67	$39.08	Highest for DOS January 29, 2019

   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 Flower Mound, Texas.
   - The carrier code for Texas is 4412 and the locality code for Flower Mound 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 59.19 ÷ 36.0391 = 1.64	Billed Amount	Lesser of MAR and billed amount
January 7, 2019	97140	1	$21.37	$21.37 x 1.64 = $35.05	$146.25	$35.05
January 15, 2019	97140	1	$21.37	$21.37 x 1.64 = $35.05	$146.25	$35.05
January 22, 2019	97140	1	$21.37	$21.37 x 1.64 = $35.05	$146.25	$35.05
January 29, 2019	97140	1	$21.37	$21.37 x 1.64 = $35.05	$146.25	$35.05
January 7, 2019	97110	1	$23.55	$23.55 x 1.64 = $38.62	$162.50	$38.62
January 15, 2019	97110	1	$23.55	$23.55 x 1.64 = $38.62	$162.50	$38.62
January 22,2019	97110	1	$23.55	$23.55 x 1.64 = $38.62	$162.50	$38.62
January 29, 2019	97110	1	$23.55	$23.55 x 1.64 = $38.62	$162.50	$38.62
					Total	$294.68

2. The total allowable DWC fee guideline reimbursement is $294.68. The insurance carrier paid $297.28. No additional payment is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC 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 payment is due. The amount ordered is $0.00.

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	February 12, 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 TAC §141.1(d).

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