



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
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AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

UHS OF TEXOMA INC

Respondent Name

STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number

M4-15-1719-02

Carrier's Austin Representative

Box Number 45

MFDR Date Received

February 9, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Since TDI moved to a 200% of MAR for outpatient services on 3/1/08 for hospital claims, we have reviewed the Medicare allowance and decided the insurance reimbursement does not meet this criteria."

Amount in Dispute: \$1,324.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In review of the dispute packet submitted by the requestor UHS Texoma, the Office will maintain that no additional reimbursement is warranted"

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
September 2, 2014 to September 29, 2014	Outpatient Hospital Services	\$1,324.36	\$0.00

FINDINGS AND DECISION

This **amended** findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent.

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 fee guidelines for outpatient hospital services.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
4. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective review of health care.
5. Texas Labor Code §408.021 establishes an injured employee's right to health care benefits.

6. The services in dispute were reduced/denied by the insurance carrier with the following explanation codes:
 - 119 – BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED.
 - 168 – BILLED CHARGE IS GREATER THAN MAXIMUM UNIT VALUE OR DAILY MAXIMUM ALLOWANCE FOR PHYSICAL THERAPY/PHYSICAL MEDICINE SERVICES.
 - 170 – REIMBURSEMENT IS BASED ON THE OUTPATIENT/INPATIENT FEE SCHEDULE.
 - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME.
 - 197 – PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION.
 - 199 – NUMBER OF SERVICES EXCEED UTILIZATION AGREEMENT.
 - 1014 – THE ATTACHED BILLING HAS BEEN RE-EVALUATED AT THE REQUEST OF THE PROVIDER. BASED ON THIS RE-EVALUATION, WE FIND OUR ORIGINAL REVIEW TO BE CORRECT. THEREFORE, NO ADDITIONAL ALLOWANCE APPEARS TO BE WARRANTED.
 - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
 - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

Issues

1. Did the disputed services exceed the benefit maximum for the time period or occurrence?
2. Did the billed charges exceed the maximum unit value or daily maximum allowance for physical therapy?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 119 – “BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED.” Per Texas Labor Code §408.021(a), "An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed." No documentation was found to support a benefit maximum or that the disputed services had exceeded it. This payment denial reason is not supported. These services will therefore be considered for reimbursement according to applicable Division rules and fee guidelines.
2. The insurance carrier denied disputed services with claim adjustment reason code 168 – “BILLED CHARGE IS GREATER THAN MAXIMUM UNIT VALUE OR DAILY MAXIMUM ALLOWANCE FOR PHYSICAL THERAPY/PHYSICAL MEDICINE SERVICES.” Per 28 Texas Administrative Code §134.403(d), “For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section” No documentation was found to support a Medicare payment policy or Division exception regarding a maximum unit value or daily maximum allowance for physical therapy or physical medicine services. This payment denial reason is not supported. These services will therefore be considered for reimbursement according to applicable Division rules and fee guidelines.
3. The insurance carrier denied payment for procedure code 97110 for dates of service September 17, 2014 and September 24, 2014 with claim adjustment reason codes 197 – “PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION.”; and 199 – “NUMBER OF SERVICES EXCEED UTILIZATION AGREEMENT.” Per 28 Texas Administrative Code §134.600(c):
 - (c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care:
 - (1) listed in subsection (p) or (q) of this section only when the following situations occur:
 - (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);
 - (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;

Per 28 Texas Administrative Code §134.600(p):

- (p) Non-emergency health care requiring preauthorization includes: . . .
 - (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:
 - (A) Level I code range for Physical Medicine and Rehabilitation, but limited to:
 - (i) Modalities, both supervised and constant attendance;
 - (ii) Therapeutic procedures, excluding work hardening and work conditioning;

No documentation was found to support an emergency. The disputed services are HCPCS Level I code range physical medicine therapeutic procedures. Preauthorization was therefore required. No documentation was submitted to support preauthorization for the disputed services. These payment denial reasons are supported. Additional payment cannot be recommended.

4. This dispute relates to physical therapy services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403(h), which requires that for outpatient services for which Medicare reimburses using fee schedules other than OPPTS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. The disputed services have a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPTS. Payment for these service is therefore calculated according to the Division's Medical Fee Guideline for Professional Services, 28 Texas Administrative Code §134.203(c). Medicare payment policies regarding multiple procedure payment reduction require that when more than one unit of designated therapy services is performed on the same date, full payment is made for the first unit of the procedure with the highest practice expense; payment for each subsequent unit is reduced by 50% of the practice expense. Reimbursement for the disputed services is calculated as follows:

- Procedure code 97110, date of service September 2, 2014: This procedure does not have the highest practice expense for this date. The Medicare payment, including multiple procedure payment reduction, is \$30.85. This amount multiplied by 3 units is \$70.89. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$110.32. The insurance carrier paid \$144.03.
- Procedure code 97112, date of service September 2, 2014: This procedure has the highest practice expense for this date. The Medicare payment, including any multiple procedure payment reduction, is \$32.16. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$50.05. The insurance carrier paid \$50.05.
- Procedure code 97110, date of service September 3, 2014: This procedure does not have the highest practice expense for this date. The Medicare payment, including multiple procedure payment reduction, is \$30.85. This amount multiplied by 3 units is \$70.89. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$110.32. The insurance carrier paid \$144.03.
- Procedure code 97112, date of service September 3, 2014: This procedure has the highest practice expense for this date. The Medicare payment, including any multiple procedure payment reduction, is \$32.16. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$50.05. The insurance carrier paid \$50.05.
- Procedure code 97110, date of service September 5, 2014: This procedure does not have the highest practice expense for this date. The Medicare payment, including multiple procedure payment reduction, is \$30.85. This amount multiplied by 4 units is \$94.52. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$147.10. The insurance carrier paid \$144.03.
- Procedure code 97112, date of service September 5, 2014: This procedure has the highest practice expense for this date. The Medicare payment, including any multiple procedure payment reduction, is \$32.16. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$50.05. The insurance carrier paid \$50.05.
- Procedure code 97110, date of service September 8, 2014: This procedure does not have the highest practice expense for this date. The Medicare payment, including multiple procedure payment reduction, is \$30.85. This amount multiplied by 2 units is \$47.26. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$73.55. The insurance carrier paid \$96.02.
- Procedure code 97112, date of service September 8, 2014: This procedure has the highest practice expense for this date. The Medicare payment, including any multiple procedure payment reduction, is \$32.16. Each additional unit is paid at \$24.29. The Medicare payment rate for 2 units is \$56.45. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$87.85. The insurance carrier paid \$100.10.
- Procedure code 97110, date of service September 10, 2014: This procedure does not have the highest practice expense for this date. The Medicare payment, including multiple procedure payment reduction, is \$30.85. This amount multiplied by 4 units is \$94.52. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$147.10. The insurance carrier paid \$144.03.
- Procedure code 97112, date of service September 10, 2014: This procedure has the highest practice expense for this date. The Medicare payment, including any multiple procedure payment reduction, is \$32.16. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$50.05. The insurance carrier paid \$50.05.

- Procedure code 97110, date of service September 12, 2014: This procedure does not have the highest practice expense for this date. The Medicare payment, including multiple procedure payment reduction, is \$30.85. This amount multiplied by 4 units is \$94.52. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$147.10. The insurance carrier paid \$144.03.
- Procedure code 97112, date of service September 12, 2014: This procedure has the highest practice expense for this date. The Medicare payment, including any multiple procedure payment reduction, is \$32.16. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$50.05. The insurance carrier paid \$50.05.
- Procedure code 97110, date of service September 15, 2014: This procedure does not have the highest practice expense for this date. The Medicare payment, including multiple procedure payment reduction, is \$30.85. This amount multiplied by 2 units is \$47.26. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$73.55. The insurance carrier paid \$96.02.
- Procedure code 97112, date of service September 15, 2014: This procedure has the highest practice expense for this date. The Medicare payment, including any multiple procedure payment reduction, is \$32.16. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$50.05. The insurance carrier paid \$50.05.
- Procedure code 97110, date of service September 17, 2014: was denied for no authorization. The denial reason is supported. Additional reimbursement is not recommended.
- Procedure code 97112, date of service September 17, 2014: This procedure has the highest practice expense for this date. The Medicare payment, including any multiple procedure payment reduction, is \$32.16. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$50.05. The insurance carrier paid \$50.05.
- Procedure code 97110, date of service September 19, 2014: This procedure does not have the highest practice expense for this date. The Medicare payment, including multiple procedure payment reduction, is \$30.85. This amount multiplied by 4 units is \$94.52. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$147.10. The insurance carrier paid \$144.03.
- Procedure code 97112, date of service September 19, 2014: This procedure has the highest practice expense for this date. The Medicare payment, including any multiple procedure payment reduction, is \$32.16. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$50.05. The insurance carrier paid \$50.05.
- Procedure code 97110, date of service September 22, 2014: This procedure does not have the highest practice expense for this date. The Medicare payment, including multiple procedure payment reduction, is \$30.85. This amount multiplied by 4 units is \$94.52. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$147.10. The insurance carrier paid \$144.03.
- Procedure code 97112, date of service September 22, 2014: This procedure has the highest practice expense for this date. The Medicare payment, including any multiple procedure payment reduction, is \$32.16. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$50.05. The insurance carrier paid \$50.05.
- Procedure code 97110, date of service September 24, 2014, was denied for no authorization. The denial reason is supported. Additional reimbursement is not recommended.
- Procedure code 97112, date of service September 24, 2014: This procedure has the highest practice expense for this date. The Medicare payment, including any multiple procedure payment reduction, is \$32.16. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$50.05. The insurance carrier paid \$50.05.
- Procedure code 97116, date of service September 24, 2014: This procedure does not have the highest practice expense for this date. The Medicare payment, including multiple procedure payment reduction, is \$27.42. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$32.71. The insurance carrier paid \$42.67.
- Procedure code 97110, date of service September 26, 2014: This procedure does not have the highest practice expense for this date. The Medicare payment, including multiple procedure payment reduction, is \$30.85. This amount multiplied by 3 units is \$70.89. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$110.32. The insurance carrier paid \$144.03.

- Procedure code 97112, date of service September 26, 2014: This procedure has the highest practice expense for this date. The Medicare payment, including any multiple procedure payment reduction, is \$32.16. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$50.05. The insurance carrier paid \$50.05.
 - Procedure code 97116, date of service September 26, 2014: This procedure does not have the highest practice expense for this date. The Medicare payment, including multiple procedure payment reduction, is \$27.42. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$32.71. The insurance carrier paid \$0.00.
 - Procedure code 97110, date of service September 29, 2014: This procedure does not have the highest practice expense for this date. The Medicare payment, including multiple procedure payment reduction, is \$30.85. This amount multiplied by 3 units is \$70.89. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$110.32. The insurance carrier paid \$144.03.
 - Procedure code 97112, date of service September 29, 2014: This procedure has the highest practice expense for this date. The Medicare payment, including any multiple procedure payment reduction, is \$32.16. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$50.05. The insurance carrier paid \$50.05.
 - Procedure code 97116, date of service September 29, 2014: This procedure does not have the highest practice expense for this date. The Medicare payment, including multiple procedure payment reduction, is \$27.42. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$32.71. The insurance carrier paid \$0.00.
5. The total recommended payment for the services in dispute is \$2,110.46. The insurance carrier has paid \$2,231.68. No additional reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	April 2, 2015
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 Texas Administrative Code §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 the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **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.