



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

TEXAS HEALTH OF DALLAS

Respondent Name

TRUMBULL INSURANCE COMPANY

MFDR Tracking Number

M4-18-3170-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

April 30, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Physical therapy services have not been reimbursed per state fee schedule rules."

Amount in Dispute: \$59.34

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Services were processed in accordance with Texas Fee Schedule & Guidelines."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Dispute Amount, Amount Due. Row 1: January 8, 2018, Outpatient Facility Services – Occupational Therapy, \$59.34, \$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 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:
- 96 – NON COVERED CHARGE(S).
- 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.
- 797 – SERVICE NOT PAID UNDER MEDICARE OPPTS.
- P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.

Issues

1. What is the recommended payment for the services in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards occupational therapy services performed in an outpatient hospital facility setting. Such services are not paid under Medicare's Outpatient Prospective Payment System but rather are paid under Medicare's Physician Fee Schedule for professional services.

Rule §134.403(h) requires that if Medicare pays using other Medicare fee schedules, reimbursement shall be made using the DWC fee guideline applicable to the code on the date the service was provided. Accordingly, payment for these services is calculated under the DWC Medical Fee Guideline for Professional Services, Rule §134.203(c):

- (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83 . . .
- (2) The conversion factors listed in paragraph (1) . . . shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors. . . .

The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by a conversion factor. The MAR is calculated by substituting the division conversion factor. The applicable division conversion factor for calendar year 2017 is \$57.50.

Reimbursement for the disputed services is calculated as follows:

- Procedure code 97110 has a Work RVU of 0.45 multiplied by the Work GPCI of 1.012 is 0.4554. The practice expense RVU of 0.4 multiplied by the PE GPCI of 1.014 is 0.4056. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.768 is 0.01536. Per Medicare policy, when more than one unit of designated therapy services is billed, full payment is made for the first unit of the code with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. The PE for this code is not the highest for this date. The PE reduced rate is \$39.28.
 - Procedure codes G8984, G8985, and G8986 represent functional information codes used for reporting purposes only. No separate payment is made.
 - Procedure code 97165 has a Work RVU of 1.2 multiplied by the Work GPCI of 1.012 is 1.2144. The practice expense (PE) RVU of 1.32 multiplied by the PE GPCI of 1.014 is 1.33848. The malpractice RVU of 0.05 multiplied by the malpractice GPCI of 0.768 is 0.0384. This code has the highest PE for this date. The sum of 2.59128 is multiplied by the division conversion factor of \$58.31 for a MAR of \$151.10.
2. The total MAR (maximum allowable reimbursement) for the services in dispute is \$190.38. This amount less the amount previously paid by the insurance carrier of \$190.39 leaves an amount due to the requestor of \$0.00. No additional reimbursement is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though not all the evidence was discussed, it was considered.

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 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

Grayson Richardson
Medical Fee Dispute Resolution Officer

May 24, 2018
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.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.