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 ARLINGTON

Respondent Name
STATE AUTOMOBILE MUTUAL INSURANCE

MFDR Tracking Number
M4-18-3219-01

Carrier's Austin Representative
Box Number 16

MFDR Date Received
May 4, 2018

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: $118.89

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "All lines have been process as per the TDI fee schedule, no further payment is due the provider."

Response Submitted by: Coventry

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
December 1, 2017 to December 12, 2017	Outpatient Facility Services – Physical Therapy	$118.89	$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:
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 96 – Non covered charge(s).
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - W3 – Request for reconsideration.

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 physical 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, December 1, 2017, has a relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.006 is 0.4527. The practice expense (PE) RVU of 0.45 multiplied by the PE GPCI of 0.991 is 0.44595. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.76 is 0.0152. The sum of 0.91385 is multiplied by the division conversion factor of $57.50 for a MAR of $52.55. 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. This code has the highest PE for this date. The first unit is paid at $52.55.
   - Procedure code 97140, December 1, 2017, has a Work RVU of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1.006 is 0.43258. The PE RVU of 0.41 multiplied by the PE GPCI of 0.991 is 0.40631. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.76 is 0.0076. The sum of 0.84649 is multiplied by the division conversion factor of $57.50 for a MAR of $48.67. This code does not have the highest PE for this date. The PE reduced rate is $36.99.
   - Per Medicare payment policy concerning correct coding initiative (CCI) edits, procedure code 97530, December 1, 2017, may not be reported with code 97140 billed on the same date. Separate payment is not recommended.
   - Procedure code 97110, December 12, 2017, has a Work RVU of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.006 is 0.4527. The PE RVU of 0.45 multiplied by the PE GPCI of 0.991 is 0.44595. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.76 is 0.0152. The sum of 0.91385 is multiplied by the division conversion factor of $57.50 for a MAR of $52.55. This code does not have the highest PE for this date. The PE reduced rate is $39.73 at 2 units is $79.46.
   - Procedure code 97530, December 12, 2017, has a Work RVU of 0.44 multiplied by the geographic practice cost index (GPCI) for work of 1.006 is 0.44264. The PE RVU of 0.54 multiplied by the PE GPCI of 0.991 is 0.53514. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.76 is 0.0076. This code has the highest PE. The sum of 0.98538 is multiplied by the division conversion factor of $57.50 for a MAR of $56.66.
   - Procedure codes G8985 and G8986, December 12, 2017, represent functional information codes for reporting purposes only. No separate payment is made.

2. The total MAR (maximum allowable reimbursement) for the services in dispute is $225.66. The insurance carrier has previously paid $262.98. The amount due to the requestor is $0.00. No additional payment 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

	Grayson Richardson	May 24, 2018
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 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.