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
SAN ANGELO MEDICAL CENTER

Respondent Name
WC SOLUTIONS

MFDR Tracking Number
M4-18-3738-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 1, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: [The requestor did not submit a position statement for consideration in this review.]

Amount in Dispute: $39.48

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "San Angelo Medical Center has been reimbursed appropriately . . . and in accordance with the 134.403 Hospital Facility Fee Guideline – Outpatient (h)."

Response Submitted by: Edwards Claims Administration/STARR Comprehensive Solutions, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
August 8, 2017 to August 18, 2017	Outpatient Facility Services – Physical Therapy	$39.48	$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:
   - 246 – This non-payable code is for required reporting only.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - W3 – Additional payment made on appeal/reconsideration.
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.

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 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).

   Medicare assigns each service a relative value unit (RVU) for work, practice expense and malpractice. The RVUs are adjusted by provider geographic practice cost indexes (GPCI). The Medicare fee is the sum of the RVUs multiplied by a conversion factor. The maximum allowable reimbursement (MAR) is calculated by substituting the Texas DWC conversion factor. The applicable division conversion factor for calendar year 2017 is $57.50.

   Per Medicare payment policy, when more than one unit is billed of therapy services with multiple procedure payment indicator '5', the first unit of the therapy with the highest practice expense for that day is paid in full. Payment is reduced by 50% of the practice expense (PE) for each extra therapy unit performed on that date.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure codes G8980 and G8979 have status indicator Q, denoting functional information codes used for reporting purposes only. No separate payment is made.
   - Procedure code 97110, August 18, 2017, has a Work RVU of 0.45 multiplied by the Work GPCI of 1 is 0.45. The practice expense RVU of 0.45 multiplied by the PE GPCI of 0.929 is 0.41805. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.809 is 0.01618. The sum is 0.88423 multiplied by the DWC conversion factor of $57.50 for a MAR of $50.84. For each extra therapy unit, payment is reduced by 50% of the practice expense. The first unit is paid at $50.84. The PE reduced rate is $38.82. The total for 2 units is $89.66.
   - Procedure code 97110, August 16, 2017, has a Work RVU of 0.45 multiplied by the Work GPCI of 1 is 0.45. The practice expense RVU of 0.45 multiplied by the PE GPCI of 0.929 is 0.41805. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.809 is 0.01618. The sum is 0.88423 multiplied by the DWC conversion factor of $57.50 for a MAR of $50.84. For each extra therapy unit, payment is reduced by 50% of the practice expense. The first unit is paid at $50.84. The PE reduced rate is $38.82. The total for 2 units is $89.66.
   - Procedure code 97110, August 11, 2017, has a Work RVU of 0.45 multiplied by the Work GPCI of 1 is 0.45. The practice expense RVU of 0.45 multiplied by the PE GPCI of 0.929 is 0.41805. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.809 is 0.01618. The sum is 0.88423 multiplied by the DWC conversion factor of $57.50 for a MAR of $50.84. For each extra therapy unit, payment is reduced by 50% of the practice expense. The first unit is paid at $50.84. The PE reduced rate is $38.82. The total for 2 units is $89.66.
   - Procedure code 97110, August 8, 2017, has a Work RVU of 0.45 multiplied by the Work GPCI of 1 is 0.45. The practice expense RVU of 0.45 multiplied by the PE GPCI of 0.929 is 0.41805. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.809 is 0.01618. The sum is 0.88423 multiplied by the DWC conversion factor of $57.50 for a MAR of $50.84. For each extra therapy unit, payment is reduced by 50% of the practice expense. The first unit is paid at $50.84. The PE reduced rate is $38.82. The total for 2 units is $89.66.
2. The total allowable reimbursement for the disputed services is $358.64. The insurance carrier paid $406.72. The amount due is $0.00. No additional payment 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 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	July 13, 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.