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 FORT WORTH

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-18-3851-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
June 7, 2018

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: $269.43

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The payment amount is correct. No additional payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
September 6, 2017 to September 28, 2017	Outpatient Facility Services – Speech Therapy	$269.43	$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:
   - 197 – PRECERTIFICATION/AUTHORIZATION ABSENT
   - 243 – SERVICES NOT AUTHORIZED BY NETWORK/PRIMARY CARE PROVIDERS.
   - 727 - PROVIDER NOT APPROVED TO TREAT TEXAS STAR NETWORK CLAIMANT. FOR NETWORK INFORMATION CALL 800-381-8067.
   - 786 - DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
   - 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

- 356 - THIS OUTPATIENT ALLOWANCE WAS BASED ON THE MEDICARE'S METHODOLOGY (PART B) PLUS THE TEXAS MARKUP.
- 723 - SUPPLEMENTAL REIMBURSEMENT ALLOWED AFTER A RECONSIDERATION OF SERVICES FOR INFORMATION CALL 1-800-937-6824.
- 18 – EXACT DUPLICATE CLAIM/SERVICE
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824
- 736 – DUPLICATE APPEAL. NETWORK CONTRACT APPLIED BY TEXAS STAR NETWORK. CALL 800-381-8067 FOR RECONSIDERATION DISCUSSION.

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. What is the recommended payment for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes:
   - 197 – PRECERTIFICATION/AUTHORIZATION ABSENT
   - 243 – SERVICES NOT AUTHORIZED BY NETWORK/PRIMARY CARE PROVIDERS.
   - 727 - PROVIDER NOT APPROVED TO TREAT TEXAS STAR NETWORK CLAIMANT. FOR NETWORK INFORMATION CALL 800-381-8067.
   - 786 - DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT.

   The insurance carrier did not maintain these denial reasons upon reconsideration. The carrier issued payment for the disputed services after reconsideration. Accordingly, the division concludes that any issues regarding pre-authorization and/or network approval are no longer in dispute.
2. This dispute regards reimbursement of speech 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).

   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 92507 has a Work RVU of 1.3 multiplied by the Work GPCI of 1.006 is 1.3078. The practice expense RVU of 0.88 multiplied by the PE GPCI of 0.991 is 0.87208. The malpractice RVU of 0.05 multiplied by the malpractice GPCI of 0.76 is 0.038. The sum is 2.21788 multiplied by the division conversion factor of $57.50 for a MAR of $127.53. The provider billed 1 unit each for 9 visits. The total MAR for 9 visits is $1,147.77.
3. The total allowable reimbursement for the disputed services is $1,147.77. The insurance carrier paid $1,147.77 plus $10.65 in interest for a total payment of $1,158.42. 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 9, 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.