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
HARTFORD CASUALTY INSURANCE COMPANY

MFDR Tracking Number
M4-18-5046-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
August 20, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Underpaid/Denied Physical Therapy Rate: CPT 97035 for DOS 03/30/2018 denied incorrectly, please see attached documentation showing there are no coding conflicts"

Amount in Dispute: $32.01

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Services were processed in accordance with Texas Fee Schedule & Guidelines, 134.403."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 30, 2018 to April 11, 2018	Outpatient Occupational Therapy: 97140, 97035	$32.01	$17.37

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. Texas Labor Code §408.021 entitles an injured employee to all required health care as and when needed.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 107 – CLAIM/SERVICE DENIED BECAUSE THE RELATED OR QUALIFYING CLAIM/SERVICE WAS NOT PREVIOUSLY PAID OR IDENTIFIED ON THIS CLAIM.
   - 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.
   - 246 – THIS PROCEDURE IS INAPPROPRIATELY BILLED. IT SHOULD ONLY BE BILLED IN CONJUNCTION WITH APPROPRIATE REQUIRED CODE.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.

- W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 1115 - WE FIND THE ORIGINAL REVIEW TO BE ACCURATE AND ARE UNABLE TO RECOMMEND ANY ADDITIONAL ALLOWANCE

Issues

1. Are the disputed services or the injured employee subject to a benefit maximum?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. What is the recommended payment for the services in dispute?
4. Is the requestor entitled to additional 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.

   Texas Labor Code §408.021(a) provides that "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."

   The insurance carrier did not present any information to support a "benefit maximum" applicable to the disputed services. This denial reason is not supported. These services will be reviewed for reimbursement in accordance with division rules and fee guidelines.

2. The insurance carrier denied disputed services with claim adjustment reason codes:
   - 107 – CLAIM/SERVICE DENIED BECAUSE THE RELATED OR QUALIFYING CLAIM/SERVICE WAS NOT PREVIOUSLY PAID OR IDENTIFIED ON THIS CLAIM.
   - 246 – THIS PROCEDURE IS INAPPROPRIATELY BILLED. IT SHOULD ONLY BE BILLED IN CONJUNCTION WITH APPROPRIATE REQUIRED CODE.

   To support the above denial reasons, the carrier's response included a printout of the claims payment calculation detail. In regard to procedure code 97035, the carrier's documentation states:

   > Rule: TX – Disallow Modality (97010-97039) codes not billed with PT codes (97110-97799

   The division takes notice that the above is not a *Texas* rule nor a requirement listed in the division's fee guidelines.

   28 Texas Administrative Code §134.203(b)(1) requires that for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply "Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers . . . and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The insurance carrier did not present any information to support that this is a Medicare payment policy.

   The denial code explanations do not state what "related or qualifying claim/service was not previously paid or identified" on the bill. Nor do the EOBs explain what "appropriate required code" was absent from the bill.

   The insurance carrier did not present any information to support these denial reasons.

   Consequently, the division concludes these denial reasons are not supported. The disputed services will be reviewed for reimbursement in accordance with division rules and fee guidelines.

3. This dispute regards occupational therapy services performed in an outpatient facility. Such services are not paid under Medicare's Outpatient Prospective Payment System but using Medicare's Physician Fee Schedule. Per DWC's *Hospital Facility Fee Guideline*, Rule §134.403(h), if Medicare reimburses using other fee schedules, DWC guidelines applicable to the code on the date provided are used for payment. DWC *Medical Fee Guideline for Professional Services*, Rule §134.203(c), requires the maximum allowable reimbursement (MAR) be determined by applying Medicare payment policies modified by DWC rules. The Medicare fee is the sum of the geographically-adjusted work, practice expense and malpractice values multiplied by a conversion factor. We substitute DWC's conversion factor to calculate the MAR. The 2018 DWC conversion factor is $58.31.

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 code 97035, March 30, 2018, has a Work RVU of 0.21 multiplied by the Work GPCI of 1.007 is 0.21147. The practice expense RVU of 0.16 multiplied by the PE GPCI of 0.986 is 0.15776. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.747 is 0.00747. The sum is 0.3767 multiplied by the DWC conversion factor of $58.31 for a MAR of $21.97. For each extra therapy unit after the first for that date, payment is reduced by 50% of the practice expense. The PE for this code is not the highest. The PE reduced rate is $17.37. The insurance carrier paid $0.00. The recommended payment is $17.37.
- Procedure code 97140, April 11, 2018, has a Work RVU of 0.43 multiplied by the Work GPCI of 1.007 is 0.43301. The practice expense RVU of 0.35 multiplied by the PE GPCI of 0.986 is 0.3451. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.747 is 0.00747. The sum is 0.78558 multiplied by the DWC conversion factor of $58.31 for a MAR of $45.81. For each extra therapy unit, payment is reduced by 50% of the practice expense. The PE for this code is not the highest. The PE reduced rate is $35.75. The insurance carrier paid $35.75, additional payment is not recommended.

4. The total MAR (maximum allowable reimbursement) for the services in dispute is $53.12. The insurance carrier paid $35.75. The amount due to the requestor is $17.37. This amount 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 evidence presented by the requestor and respondent available 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 established that additional reimbursement is due. As a result, the amount ordered is $17.37.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $17.37, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	September 28, 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 division must receive the request within twenty days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the division, using the contact information listed on the form, or to the field office handling the claim.

The party seeking review must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Include a copy of this *Medical Fee Dispute Resolution Findings and Decision*** together with any other information required by 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.