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
SENTRY CASUALTY COMPANY

MFDR Tracking Number
M4-18-5201-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 27, 2018

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: $48.67

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have verified that this bill paid correctly according to the Texas Fee Schedule."

Response Submitted by: Sentry Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 1, 2017	Outpatient Facility Services – Occupational Therapy	$48.67	$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:
   - 236 – THIS PROCEDURE OR PROCEDURE/MODIFIER COMBINATION IS NOT COMPATIBLE WITH ANOTHER PROCEDURE OR PROCEDURE/MODIFIER COMBINATION PROVIDED ON THE SAME DAY ACCORDING TO THE NCCI OR WORKERS COMPENSATION STATE REGULATIONS /FEE SCHEDULE REQUIREMENTS.
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issue

What is the recommended payment for the services in dispute?

Findings

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 2017 DWC conversion factor is $57.50.

Reimbursement is calculated as follows:

- Procedure code **97140**, November 1, 2017: Per Medicare payment policy regarding correct coding initiative (CCI) edits, code 97140 (manual therapy) may not be reported with code 97760 (orthotic management and training) billed on the same date. A modifier can be used to distinguish separate services, which may justify separate payment if supported by the medical record. However, the health care provider did not bill this code with an appropriate modifier. Payment for this service is therefore included in the reimbursement for the primary service code 97760. Additional payment is not 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 emphasizes that the findings in this decision 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 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	November 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 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.